New standards for the initial education & training of pharmacists

Purpose
To agree new education & training standards for pharmacists wanting to register in Great Britain.

Recommendations

The Council is asked to agree:

i. Future pharmacists: standards for the initial education & training of pharmacists (standards for GB-trained pharmacists) (Appendix A); and

ii. Standards for the initial education and training of pharmacists wanting to register in Great Britain (standards for non-EEA-trained pharmacists) (Appendix B).

1.0 Introduction

1.1 At its October 2010 meeting, Council agreed to reconult on new standards for the initial education and training of pharmacists. A public consultation was held from the 1 November 2010 to 4 February 2011. Respondents were asked to use Survey Monkey to provide data online; those who sent in responses by other means had their responses entered into Survey Monkey manually.

1.2 To supplement the online facility, five seminars were held:

1. 17 November 2010: Cardiff University, Wales
2. 22 November: General Pharmaceutical Society, London
3. 24 November: The Queen's University, Belfast, Northern Ireland
4. 26 November: Strathclyde University, Scotland
5. 29 November: University of Manchester
All schools of pharmacy were represented and there were 168 attendees in total.

For the first time, the consultation included PPI events [note: one is yet to be held]:

1. 6 January 2011: Colwyn Bay [North Wales]
2. 12 January 2011: Llandrindod Wells [Mid Wales]
3. 20 Jan 2011: Carmarthen [West Wales]
4. 24 Jan 2011: Cardiff [South Wales]
5. 21 Feb 2011: Warrington [England]
7. 15 April 2011: Glasgow [Scotland]

There were 111 attendees in total. We intend to write up our experience of running PPI events and share it with GPhC colleagues and schools of pharmacy. However, the most frequently articulated points in PPI seminars were:

1. *The need for patient involvement in initial education & training – both patients and groups of users with specific needs.* Comment: There are financial constraints preventing more patient involvement in the MPharm but this comment will be fed back to schools. NB Standard 5.5 is ‘The MPharm degree curriculum must include practical experience of working with patients, carers and other healthcare professionals.’

2. *Inter-professional learning.* Comment: These standards make IPL compulsory for the first time. NB Standard 10 includes ‘learning based on experience that provides education in inter-professional practices and procedures with other healthcare professionals.’

3. *English language proficiency.* Comment: That patients/members of the public in seminars raised concerns about the language competence of pharmacists they have interacted with does not mean it is a problem in schools. We enquire about this routinely in accreditation visits and it has never been flagged up as a problem.

4. *Early exposure to practice.* Comment: This is a concern but sustained early exposure across the sector is hampered by a lack of funding. MPC could help with this.

5. *Being taught by pharmacists.* Comment: The pharmacist academic workforce is vulnerable – something which has been acknowledged by MPC. At 9.1 the standards are explicit about the need for and the value of academic pharmacists.
1.3 Once the consultation had closed, the responses were analysed independently. The analysis is included in these papers (Appendix C). It should be noted that there were 370 engagements in total.

1.4 The draft standards have been modified in light of comments and are being presented for approval. Modifications have been highlighted for convenience.

2.0 Comments on responses

2.1 In general, responses were strongly positive. As is always the case with consultations, further clarity and elaboration was requested about particular points. On the whole these will be dealt with by working with schools of pharmacy to ensure we share an understanding of what is meant and required. The principal way we will do this is by adding a clarification and planning visit for each school in advance of their reaccreditation against the new standards. This should be a cost effective way of dealing with queries and potential misunderstandings. The temptation is to write overly detailed definitions of everything in standards documents but the reality is that no amount of explanation will clarify ‘appropriately qualified’ or ‘sufficient resources’ to everyone’s satisfaction.

2.2 Comments on responses to individual questions:

Question (Q) 1: [Future Pharmacists] Overall, are the 10 standards fit for purpose? and Q 2: [OSPAP] Overall, are the 10 standards fit for purpose? Comment (C) 1: A concern that there is insufficient science in the standards [NB consultation comments have been italicised]. Response: We have made reference to the centrality of science (including behavioural science) to the pharmacy curriculum in many places in the standards. In light of this, it is difficult to know what would allay fears about the amount of science in the curriculum. Action: One concrete step we have taken is ask the team that drafted the indicative syllabus to expand some of the science sections so there is a better balance between science and practice. Members will see that the expansion is substantial and has given science greater prominence. Also science has been highlighted in boxes elsewhere in the document.
C 2: Need for business/management/clinical leadership skills. These issues have been raised on a number of occasions. We recognise that there is further work to do in this area and will be discussing how to move this forward by exploring the utility of the National Leadership Council’s Clinical Leadership Competency Framework. We will progress this issue as part of a forward programme of work following on from the approval of the standards.
Q3: [Future Pharmacists] Are the individual standards fit for purpose? and Q 4: [OSPAP] Are the individual standards fit for purpose?
Respondents made detailed comments about the individual standards, which are reproduced at Appendix 1. Most points were comments or requests for clarification, which will be dealt with in other documents rather than in the standards themselves.

Q5: [Both documents] Are we right to emphasise the importance of assessment and feedback?
C 1: Yes. Action: We will make assessment a focus of the first round of reaccreditations against the standards.

Q6: [Future Pharmacists] Do you agree with our position on research in the MPharm degree?
C 1. Is the position of research secure in the new standards? By asking an open question about research we have sewn the seeds of doubt about the importance of research in an MPharm degree. This was always a risk. Action: Revise the standards to be clear that a piece of sustained research should be a feature of MPharm degrees.

Q 7: [Future Pharmacists] Are the learning outcomes in Standard 10 at the right level? and Q 8 [OSPAP] Are the learning outcomes in Standard 10 at the right level?
No comments.

Q 9 [Future Pharmacists] Are the learning outcomes sufficiently comprehensive? and Q 10: [OSPAP] Are the learning outcomes sufficiently comprehensive?
No comments (as the science issue has been dealt with elsewhere).

Q 11: [Both documents] Do you agree that the indicative syllabi give sufficient prominence to relevant science?
This issue has been dealt with elsewhere.

Q 12 [Future Pharmacists] Is the indicative syllabus fit for purpose? and Q 13: [OSPAP] Is the indicative syllabus fit for purpose?
C 1: Ossification of the syllabus. Comment: As is always the case, the moment a syllabus is agreed, it starts to age. Action: Issue periodic supplements if syllabus areas need updating. Also, MPC may give us another opportunity to revisit the syllabus.
3.0 **Equality and diversity implications**

3.1 The new initial education & training standards address equality and diversity issues directly. The most obvious manifestation is standard three – equality, diversity and fairness, but equality and diversity requirements are spread across the standards as a whole.

3.2 The accreditors are responsible for reporting on equality and diversity issues as part of the new accreditation process for MPharm degrees. They have been trained in equality and diversity issues already. This knowledge will be integrated with training in the new equality & diversity reporting requirements of accreditation at a later date.

4.0 **Communications implications**

4.1 We discuss standards with schools through the Council of University Heads of Pharmacy on a regular basis. If the revised standards are agreed, they will be sent to schools.

4.2 Because the new standards coincides with the production of a new accreditation methodology, every school will be provided with and additional pre-visit to discuss the new initial education & training standards and new methodology. Schools will be told this formally once the standards are released.

4.3 The formal GPhC response to the consultation will be prepared after this meeting and in light of Council’s comments.

5.0 **Resource implications**

5.1 The only outstanding costs associated with these standards are printing costs of £8k.

6.0 **Risk implications**

6.1 Not agreeing the will standards mean schools will have to continue to use standards which are ageing rapidly and will not be fit for purpose. In particular, they barely mention patient/public safety and student fitness to practise is not mentioned at all.
7.0 Associated documents

7.1 The other documents associated with this item are:

1. Standards for the education and training of pharmacists: an analysis. This is the independent analysis of the consultation responses.

2. Future pharmacists, standards for the initial education and training of pharmacists. The final draft of the education & training standards for GB-trained pharmacists. Note that changes to the text have been underlined and are linked to comments explaining the change.


Recommendations

The Council is asked to agree:

i. Future pharmacists: standards for the initial education & training of pharmacists [standards for GB-trained pharmacists]; and

ii. Standards for the initial education and training of pharmacists wanting to register in Great Britain [standards for non-EEA-trained pharmacists].

Damian Day, Head of Education & Quality Assurance
General Pharmaceutical Council
damian.day@pharmacyregulation.org, tel 020 3365 3455

21 April 2011
Appendix 1: Detailed comments in individual standards with responses

Standard 1 – Patient and public safety

The overwhelming response was supportive of the proposals - other than a few counsels of despair that patient and public safety could never be guaranteed whatever steps GPhC took.

The PPI respondents did not seek to try to engage with some of the more technical standards (e.g. support for academic staff) later on but were very pleased to have the opportunity to talk about patient safety where they felt they had informed views and expertise. It is noteworthy that all the PPI seminars raised issues under this Standard about basic skills (e.g. record keeping, awareness of particular conditions or communications skills to name just three). Comment: We have learnt a lot from the PPI seminars but most of the comments are best dealt with in dialogue with schools about how PPI work could be integrated into individual MPharms. In other words, it's a more a practical matter rather than something which requires standards to be changed.

Academic responses were looking at higher level and more abstract issues. Each sector, therefore, played to its strengths rather than making mutually exclusive responses.

To address the concerns expressed about student fitness a section has been added to the standards:

**Note**

1.12 This standard should be read in conjunction with the GPhC's Guidance on student fitness to practise procedures in schools of pharmacy, which has further guidance on what constitutes student fitness to practise.

Some very specific reservations and/or points raised – mostly by the academic sector - included:

- Practicality issues in implementation. **Comment:** A lot of this work has been done already through the introduction of the Code of Conduct for Pharmacy Students and Guidance on Student Fitness to Practise Procedures in Schools of Pharmacy. However, we accept that it will take time to bed in.
- The balance between students' and patients' rights in the area of students' health. **Comment:** This is dealt with in our Guidance on Student Fitness to Practise Procedures in Schools of Pharmacy – explicit reference to it has been added to the standard.
- Consistency between the SoPs. **Comment:** Consistency will be achieved in three ways: 1. by schools talking to each other, 2. by the GPhC facilitating 1. (which we will be doing) and 3. through accreditation – accreditors will have to satisfy themselves that this standards is being met and will be able to benchmark schools with others and offer them advice on good practice.
• Squaring the circle between placing students in challenging (and hence learning) situations and never letting them work beyond their competence. Comment: This is a matter for schools.

• Policies relevant to a work place in the preregistration year might not fit with a learning environment in a university. Comments: There is no suggestion in the standards that policies should be applied across the MPharm and pre-reg where that would not be appropriate. It may well be the case that students are bound by university procedures while studying and by employer procedures while training.

• Implications of the MPharm being a guarantee of fitness to practise in the preregistration year. Comment: The position is that schools must confirm that to the best of their knowledge a student is fit to enter pre-registration. Schools are not expected to be omnipotent but are expected to take reasonable steps to ensure they have sought appropriate reassurances. The FTP guidance document is helpful here: ‘3.7 Schools are responsible for ensuring students are fit to practise as students....Fitness to practise as a student is the absence of evidence that a student is unfit to practise as a student.’

Standard 2 – Monitoring, review and evaluation of initial education and training

While the proposals enjoyed support, there was a small body of much more critical comment here from the academic sector about the need for more clarification. Comment: It should be borne in mind that the standards are part of a suite of documents and are the highest level document of the suite. The operational document for accreditations – the Accreditation and Recognition Manual has more detailed comments on reporting requirements.

The generality of responses, though, greatly welcomed the inclusion of the public and patients, even if not all were sure how this could best be achieved. Several respondents called for a major training programme for this activity. The community pharmacy sector asked for employers also to be written into this standard.

Amongst other issues raised were:

• Resource implications and implementation queries: Comment: Higher education resourcing is in a state of flux at the moment and it is difficult to gauge the effect of changes on MPharm degrees. But that isn’t a function of these standards and will affect all courses at university. The practicalities of implementation will be dealt with in the Accreditation & Recognition Manual and through dialogue with schools.

• Training programme for PPI involvement in courses. Comment: This comment doesn’t appear to relate to this standard. However, we feel that the best way to tackle this important issue is to raise PPI involvement in courses delivery with schools and then discuss what support mechanisms should be in place to make PPI involvement effective.

• Would patient feedback be better sought at a national or local level? Comment: From the point of view of national standards, a national perspective is needed but at the local level, local views could be equally important.

• The proposals needed to differentiate better between the MPharm and the preregistration year. Comment: Sections referring to pre-registration have been italicised.
• The standard must not lose sight of the need for expert pharmacists' input into review. Comment: There is no suggestion that the views of pharmacists would not be sought. 2.3 makes it a requirement that stakeholder views must be sought and university course development procedures will ensure that the views of pharmacists in schools are sought.
• Appropriate techniques at appropriate stages and the right balance in the assessment diet overall. Comment: This comment relates to Standard 10. There it is made clear that teaching/learning and assessment must be aligned.
• More explicit accounts of what is to be measured, by whom and in what way. Comment: There is a danger in being too prescriptive but the Accreditation & Recognition Manual will give further guidance on what is required.
• Care needed in using student and trainee feedback to make course changes. Comment: Agree, but students and trainees are key stakeholders in education & training.
• Use of the term 'holistic' evaluation. Comment: MPC and others made the point that holistic might be confusing so an alternative wording has been used. The point is that the totality of a course needs to be evaluated not just component parts.

Standard 3 – Equality, Diversity and Fairness

This standard also attracted almost universal support, but there was a strong minority view among the (academic) supporters who queried if GPhC, as regulator, needed to play so active a role when so many other bodies – and the universities themselves not least – also had explicit duties. (NB. CUHOP acknowledged this but then pointed out the value of explicit reassurance to the public in this area).

Amongst other comments made were:

• Risks of burden and duplication. Comment: In time, when E & D become embedded in programmes, considering such issue will be routine and will not be seen as additional or burdensome, we hope.
• Issues around plain English should be located here. Comment: It is unclear what this refers to.
• Need to correlate it with other standards. Comment: This is an overarching standard and its principles will become better understood and better embedded in time.
• There might be adverse implications for preregistration tutors who were not so well supported here as SoP staff. Comment: Agree, but unless schools are responsible for pre-registration it is a matter for employers.
• Rapport with patients. Comment: This PPI comment is an example of the wider principles embedded in the Code of Conduct for Pharmacy Students, especially 3. Show respect for others. The Code is now being used in schools as a teaching tool, so student understanding of issues like rapport with patients should become better understood.
• Translation/interpretation. Comment: A detailed comment which is covered by 4. Encourage patients and the public to participate in decisions about their care in the Code of Conduct.
- Need for regular E & T updates. Comment: MPC pointed out that there is a need to ensure that E & T training is updated as necessary. This has been added to the standard.

Two respondents specifically asked for this standard to be amalgamated with Standard 4.

The PPI input stressed that this standard as it affected patients had to be underpinned by pharmacists’ ability to establish rapport with them (see above). This carried the discussion into areas such as empathising with patients (however challenging), equity of treatment between different patients and groups of patients, communications skills and patients’ confidence in the pharmacist’s core skills. The PPI respondents often raised issues about translation and interpretation here, but this about the delivery of (NHS) services more generally and not one relating to the standards for initial pharmacy education and training.

Standard 4 – Selection of Students and Trainees

There was clear support for the principles underlying the proposals, although some queried whether the regulator was the most appropriate body to implement them. The balance between sectors was that all, again, played to their strengths. The PPI input looked at the professionals who would emerge eventually as a result of selection procedures while the academics had expert views to offer on the procedures themselves.

The academics raised two very particular points here. The first was whether the implications of this standard pointed towards mandatory interviews for all MPharm applicants (and BPSA lobbied hard for this), and the second was whether an explicit test of numeracy was needed. (This was then extended into the query as to whether a calculations paper should be set for entry to preregistration training in England and Wales).

Comments:

- Regulator’s role in admission and selection. Comment: The regulator is not involved in admissions directly, which is a university/pre-reg employer matter. At 4.2 we have specified what should be included in the admissions process but not how it should be conducted – that is up to universities.
- Mandatory interviews for admission. Comment: We have not stated that interviews are mandatory but as a general principle, the admission process should assess an applicant’s suitability to be admitted to a professional/academic course.
- Mandatory numeracy tests for admission. Comment: The standards state that applicants must ‘meet numeracy requirement’. Setting the requirements and checking them is a matter for schools.
- Whether all applicants should be interviewed: Comment: We have left this decision to universities. MPC commented that interviews should be used.
- The admissions role in creating professionals. Comment: An admissions process cannot guarantee that a student is fit to be a pharmacist in five years time. However, it should check that an applicant is not wholly unsuitable.
• Will this standard lead in the direction of uniformity (based on GPhC directions) for all SoPs? Comment: We do not see why this would be the case as schools retain control of the admissions process.
• Equity of opportunity for preregistration trainee applicants needed to be maintained. Comment: This is not something the regulator can guarantee.
• Would selection criteria also have to be applied to access to MPharm clinical placements? Comment: Which students are sent on which placements is a matter for schools. However, schools must ensure that students are fit to go on placements. For example, a fitness to practise issue that comes to light shortly before a placement may render a student unsuitable to go on a placement at that time. These issues are comparatively rare.
• Consistently full information needed to be given to all MPharm applicants to all SoPs. Comments: Agree. There is guidance on this in the Guidance on student fitness to practise procedures in schools of pharmacy in sections 2.3-2.5.
• There was no point in allowing an applicant to start an MPharm who could not deal with difficult patients in due course and this should be assessed for. Comment: There is a balance to be struck in admissions between recognising ability but also the immaturity of some applicants. Hopefully the courses will equip promising but less mature applicants to deal with difficult patients in time.
• Maintaining equity in applications between GB, OSPAP and EEA groups. Comment: From a standards perspective there is equity within each of those groups but their needs as groups are different. GB applicants are student applicants, OSPAP applicants are overseas pharmacists and EEA applications must be processed in accordance with Directive 2005/36. All processes must meet the main standard, that processes must be 'open, fair and comply with relevant legislation' but may vary between groups.
• Involve professionals (e.g. social workers) in selection procedures (a PPI suggestion). Comment: Some courses require external input into admissions, for example social work courses always have an external social worker on the interview panel. Many schools do use pharmacist members of staff as admissions officers but we are unsure if this is always the case. We will clarify the issue with schools (and also the PPI point about using externals for interviewing).

Standard 5 – Curriculum delivery and the student experience

The standard was accepted very widely as a basis for implementation and development. Most respondents felt that there could be more flesh on the bones here. In contrast, other – especially academic – responses counselled against being too prescriptive. Comment: Given the contrasting views, it is difficult to know what changes to make to the standard. Given that academics will have to work with the standards, their view should prevail. We will deal with specific comments during the accreditation process.

Although they offered some comments on this standard, the PPI seminar attendees – not surprisingly – could not claim the same level of detailed insight and expertise as they had for some earlier standards.

Academics were concerned about standard 5.10, which requires students to fail if they demonstrate unsafe practice. Comment: Particularly in the seminars, academics asked what would happen if a student failed a high stakes examination at the end of a course.
If a student consistently demonstrates that they are unsafe, they will have to be failed. But, as the standard points out at 5.7 the overall assessment strategy should include diagnostic, formative and summative assessments. This should mean that by the time a student takes a high stakes assessment, they have had their strengths and weaknesses diagnosed and have had opportunities to practise whatever is being tested in the high stakes assessment in formative assessments earlier in the course.

NB CUHOP did not comment on this standard (or the following two).

**Standard 6 – Support and development for students and trainees**

Very few narrative responses were received, and most of them were about how it correlated with the other standards or with the overall five/two year experience. This made it one of the standards accepted with least query or reservation.

The largest area of concern was expressed for those students unable to progress to the preregistration year for reasons other than just failing the MPharm. **Comment:** The standard makes it clear that a student’s academic and welfare needs must be addressed during the course. The number of students who fail to enter pre-reg (other than on grounds of academic failure) is very small.

Several respondents commended the consistency in applying this standard across all environments. **Comment:** It is true that students and trainees have different needs and that their needs are met in different ways. It is most consistent in universities, the NHS and large community employers but less so in smaller community settings. This will remain the case unless, proposals such as MPC’s allow greater consistency to be built into support systems at the local/regional level.

More could be said here about inter-professional learning and working. **Comment:** Interprofessional learning is in its infancy in most schools but we will monitor it and strength this standards at a later date if it is appropriate to do so.

**Standard 7 – Support and development for academic staff and preregistration tutors**

This standard attracted greater explicit support than 5 or 6, and, again, its basis was unarguable, from the point of view of respondents.

There was, though, a great deal of comment in detail starting with three (academic) respondents dismissing it as patronising and irrelevant as a GPhC standard. The irrelevance referred to a perceived duplication with universities’ existing procedures here and an inappropriate departure from the regulator’s proper functions, although a counter argument was that the regulator staking a claim to this territory would strengthen MPharm course authorities’ hands. There was a body of opposition to the perceived distinction being drawn in this standard between pharmacist and non-pharmacist teaching staff. **Comment:** The standard does not seek to duplicate anything, simply to make sure that mechanisms are in place and that they are in place for all staff.

Among other more detailed comments were:
- Pre-reg comment: This, and standard 4, were the two where Scottish respondents felt that NHS Education Scotland’s provisions meant they were already in compliance with the proposals, but the corollary being to ask how GPhC envisaged implementation in England and Wales. Comment: The NHS Scotland pre-reg scheme makes arrangements for staff and tutor development and support, as the respondents point out. The respondents seem to be assuming that there will be national arrangements put in place in other countries: this is the case in Wales (but in a different format) but in England, support and development is made available through a number of different structures, including universities, community employers and the NHS.

- One academic respondent and two PPI seminars identified this standard as being where inter-professional working and “joined-up care” should reside. Comment: Support and development will be needed as ILP work develops but its natural home is Standard 10, which includes several learning outcomes about IPL.

- One respondent felt that the issue of staff:student ratios needed exploring here. Comment: Staff:student ratios or, rather workload, are dealt with in Standard 9 – Resources and capacity. Rather than specifying staff:student ratios we ask universities to argue the case for a particular pattern of delivery. In doing so we are not avoiding the issue, but we are recognising that the staff:student ratio is a metric for classroom delivery and does not properly take account of directed learning, private study and online delivery which are, increasingly central to course delivery.

- There should be stronger links to CPD. Comment: CPD is mentioned in the standard at 7.3.

Standard 8 – Management of initial education and training

Respondents felt that this standard was appropriate and to be expected.

Few of the PPI seminars addressed it in any detail.

The big issue raised by many academic respondents here was resource implications if this standard, and the others more generally, were extended to clinical placements and preregistration training. Comment: As has been stated already, the funding base for higher education (and also pre-registration training) is shifting. Clearly it is something we have to monitor.

Meticulous application of this standard to short placements within the MPharm could be an “overkill” and a disincentive to developing them. Allowing the SoPs greater flexibility than the standard implied might also help address resource problems. Comment: Agree. QA arrangements for placements must be proportionate.

BPSA argued for a minimum level of clinical exposure in the MPharm to be set within this standard. Comment: As pharmacy becomes a more clinical profession, setting minimum standards for clinical work seems logical. However, the current funding arrangement classifies the MPharm as a science course without clinical levels of funding. A several heads of school have pointed out, until clinical funding is forthcoming, it would be unreasonable for the regulator to mandate levels of clinical work.
The role of other stakeholders was not discussed in the proposals and this was felt to be a lack. Comment: It is true that this standard is linked most closely to MPharm delivery (but also to pre-registration training). If MPC’s proposals are implemented, this standard will have to be revisited to make explicit the management responsibilities of stakeholders involved in delivering an integrated degree.

**Standard 9 – Resources and capacity**

All respondents agreed with the proposition that pharmacy initial education and training should be adequately resourced. The PPI respondents, when they addressed this standard, contextualised it into general concerns about resource reduction in health and education.

More than any other one standard, academic respondents queried the definitions and criteria being used for this standard. In general this related to the use of terms like ‘appropriate’ and ‘adequate’. Comment: We expect a school to explain what is appropriate and adequate in its particular circumstance. To be any more specific in a standard would be overly restrictive.

The resource constraints for universities generally and MPharms in particular were a recurrent theme in the responses.

Amongst more detailed comments were:

- One respondent felt that this standard had to be supported by workforce planning. Comment: The regulator cannot influence workforce planning. However, we would comment that the Centre for Workforce Intelligence was set up a year ago to provide data on workforce needs and its first pharmacy study is about to be produced.
- The standard had to be linked to quality issues, not just numerical ones. Comment: We would argue that it is. For the first time in standards we have specified the qualitative skills mix required to deliver an MPharm.
- This standard begged the whole question of the funding regime(s) for pharmacy initial education and training, and GPhC could not set realistic standards without reference to this. Comment: Pharmacy is in the same situation as the rest of higher education in terms of funding. However, the regulator’s concern must be to set the right standard.
- The standard would be undeliverable without strong professional leadership. Comment: Agree, which is why this is stated unambiguously in the standard.
- The specific roles of pharmacists in initial education and training needed to be elaborated together with their need to be qualified teachers in Higher Education – just pharmacists or just well qualified teachers were not enough to meet this standard. Comment: Specific roles are a matter for schools, who are responsible for ensuring they have the right skills mix to deliver their course.
- Do staff:student ratios need to be addressed under this standard (as well as under standard 7)? Comment: SSRs have been discussed above.
Standard 10 – Learning outcomes

Only one respondent expressed fundamental reservations about the proposals as an appropriate point of departure. Few of the PPI seminars discussed this standard.

The answers elsewhere about there not being sufficient acknowledgement of science in the curriculum were reflected in those respondents’ comments on LOs. Comment: This observation has been addressed elsewhere.

CUHOP commented that this standard was different from the others. Comment: It is different: standards 1-9 are the framework within which standard 10 is delivered.

Specific queries and comments included:

- Would this standard supersede the current preregistration Performance Standards? Comment: As part of the development process, the pre-registration performance standards were mapped against the pre-reg learning outcomes in Standard 10. Part of the advance work schedule for the standards will be to revise the Pre-registration Manual to harmonise it with the standards.

- The LOs seemed more appropriate to practice than to pure science learning. Comment: This is intentional. The science – stated unambiguously in the Indicative Syllabus – supports the achievement of the learning outcomes. There are primarily clinical in focus because virtually all students end up working in community or hospital settings.

- Can safe and effective practice be assessed effectively as an LO? Comment: We argue that it can, given the right assessment methods are used.

- LOs should be mapped onto the indicative syllabus and the preregistration performance standards and take account of levels (in the QAA qualifications framework). Comment: This kind of mapping would create a straightjacket for schools and we would resist this. In the seminars, a few academics wanted mapping but the majority did not.
Future pharmacists

Standards for the initial education and training of pharmacists

April 2011
Standards for the initial education and training of pharmacists

This document provides schools of pharmacy\textsuperscript{1} with the standards for the initial education and training of pharmacists.

The requirements for submitting a degree for accreditation are in our accreditation and recognition manual which is published separately.

This document may also be of interest to prospective and current pharmacy students and pre-registration pharmacist trainees, those involved in the initial education and training of pharmacists, pharmacy professionals and members of the public.

\textsuperscript{1}The term 'school of pharmacy' is used throughout this document. It is used generically to describe the academic unit in a university with primary responsibility for delivering an accredited course. Depending on institutional structures a 'school' may be a school, department, division, faculty or other grouping. Whatever its name, for accreditation purposes a university must define the unit with primary responsibility for delivering an accredited course.
About us

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and pharmacy premises.

It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public, and in particular those members of the public who use or need the services of pharmacy professionals or the services provided at a registered pharmacy.

Our principal functions include:

- setting standards for conduct, ethics, proficiency, education and training, and continuing professional development (CPD);
- establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies;
- establishing fitness to practise requirements, monitoring pharmacy professionals' fitness to practise and dealing firmly and fairly with complaints;
- approving qualifications for pharmacists and pharmacy technicians;
- maintaining a register of pharmacists, pharmacy technicians and pharmacy premises.

We will aim to ensure that regulation is fair and proportionate – that is, in line with the level of risk posed to public health, safety and wellbeing – and not over-burdensome. We want it to be flexible enough to respond to the changing demands made of the profession and to allow for innovation at the same time as maintaining high quality practice.

The delivery of education and training

The initial education and training of pharmacists in Great Britain is:
In Great Britain the four-year MPharm degree is separate from the 52-week pre-registration training with one exception: a five year MPharm degree with two intercalated periods of preregistration training. We expect the MPharm degree + pre-registration training model to predominate in the short term, with an integrated degree combining academic study and pre-registration training being a serious aspiration. However, these standards have been written in such a way that they could support an integrated degree because we have not been prescriptive about delivery structures.

The learning outcomes in Standard 10 refer to outcome levels for an MPharm degree and outcome levels for pre-registration training. Unless a school of pharmacy decides to offer an integrated degree, the pre-registration outcomes are for reference and course design purposes only. As schools are not responsible currently for delivering pre-registration, anything related exclusively to pre-registration has been italicised for clarity. It should be borne in mind, however, that even though most MPharm degrees are separate from pre-registration training, they are a preparation for it.

Science into practice

\footnote{Titles of documents are italicised too.}
Requirements for the initial education and training of pharmacists

For students studying in Great Britain, there are three routes to registration\(^3\) as a pharmacist, either
- a four-year MPharm degree (part of which may be studied overseas); then
- 52 weeks of pre-registration training; and
- our Registration Assessment (an examination).

Normally, this route to registration must be completed in eight years.

or

- a two-year part-time foundation degree in pharmacy\(^4\) (comprising Year 1 of an MPharm degree plus work experience and study skills); then

\(^3\) The maximum period for completing a route to registration may be adjusted pro rata for periods of part-time education or training and for other legitimate, documented reasons.

\(^4\) The registration process includes health, good character and identity checks.
• years 2-4 of an MPharm degree; then
• 52 weeks of pre-registration training; and
• our Registration Assessment (an examination).

Normally, this route to registration must be completed in nine years.

or

• a five year MPharm degree, including intercalated blocks of pre-registration training equaling 52 weeks; and
• our Registration Assessment (an examination).

Normally, this route to registration must be completed in eight years.

5 This refers to accredited foundation degrees not unaccredited foundation degrees for pharmacy technicians.
Standard 1 – Patient and public safety

Standard

1. There must be clear procedures to address concerns about patient safety arising from initial pharmacy education and training. Concerns must be addressed immediately.

Criteria to meet this standard

1.1 There must be effective systems in place to ensure that students and trainees:

- do not jeopardise patient safety;
- only do tasks for which they are competent, sometimes under supervision;
- are monitored and assessed to ensure they always practise safely. Causes for concern should be addressed immediately;
- have access to support for health, conduct and academic issues;
- must not be awarded an accredited degree or pass pre-registration training if they might pose a risk to patients or the public. Where an accredited degree cannot be awarded, it may be acceptable to award another, unaccredited qualification such as a Certificate/Diploma or BSc;
- understand what is and what is not professional behaviour and are familiar with the GPhC’s Code of Conduct for Pharmacy Students (2010)/Standards of conduct, ethics and performance (2010);
- understand what fitness to practise mechanisms apply to them. All schools of pharmacy must have fitness to practise procedures to deal with student causes for concern;
- undergo required health and good character checks;
- understand that it is an offence to impersonate a pharmacist. Pharmacists are registrants of the GPhC.

Evidence required for meeting this standard

1.2 Evidence sources used to demonstrate meeting this standard include

- fitness to practise policies;
- premises inspection reports;
- pre-registration tutor assessments of trainees.

1.3 The required evidence should include:

- evidence that the Code of Conduct for Pharmacy Students/Standards of conduct, ethics and performance are used to promote professional conduct;
• summary outcomes of student fitness to practise hearings;
• summary outcomes of premises inspection reports;
• analyses of pre-registration tutor assessments of trainees and follow up actions.

Guidance on meeting this standard

1.4 Anyone who teaches, supervises, counsels, employs or works with students and trainees has a responsibility to protect patients and the public. Where serious concerns are raised about a student or a trainee they must be investigated as soon as possible.

1.5 Students and trainees should not be put in a situation where they are asked to work beyond their competence and they must be supervised where necessary.

1.6 Anyone responsible for the initial education and training of pharmacists has a responsibility to share information relating to health, conduct or performance of students and trainees with appropriate people. A student or trainee should be asked to agree to this. If they do not or cannot agree, consideration must be given to whether disclosure should take place on patient safety grounds. Patient safety is paramount at all times.

1.7 Students and trainees must not be allowed to continue education and training if they pose a risk to patients or the public.

1.8 By awarding an accredited degree a university is confirming that a pharmacy graduate is fit to enter pre-registration training. If pre-registration training is included in a degree, students must not be allowed to enter a training period unless they are fit to do so. The latter point applies to degrees with intercalated periods of pre-registration training as well as integrated degrees.

1.9 To be eligible to apply to register as a pharmacist, a trainee must have been evaluated successfully by their tutor at several points in the 52 weeks of pre-registration training. The training may be continuous or in blocks.

1.10 Towards the end of the 52 weeks of pre-registration training, a tutor signs off a trainee to confirm they have met the pre-registration performance standards.

1.11 School fitness to practise policies and procedures must be introduced to students as developmental tools as well as instruments of public protection.
Note

1.12 This standard should be read in conjunction with the GPhC’s *Guidance on student fitness to practise procedures in schools of pharmacy*, which has further guidance on what constitutes student fitness to practise.

Comment (DGS): Added in response to consultation feedback about the need for further student Pp guidance.
Standard 2 – Monitoring, review and evaluation of initial education and training

Standard

2. The quality of pharmacy education and training must be monitored, reviewed and evaluated in a systematic and developmental way.

Criteria to meet this standard

2.1 There must be systems and policies in place covering the following

- information about roles & responsibilities and lines of accountability
- university information on:
  - entry requirements;
  - the quality of teaching, learning and assessment;
  - the quality of placements and other practice learning opportunities;
  - appraisal and feedback systems for students and trainees;
  - supervision requirements;
  - educational resources and capacity.

These must be monitored, reviewed and evaluated systematically. When an issue is identified it must be documented and dealt with promptly.

- pre-registration tutors evaluating trainees. To do this, tutors must have access to reliable evidence about a trainee's performance. Tutors must be competent to assess the performance of trainees
- the quality and development of pre-registration tutors.

Evidence required for meeting this standard

2.2 Evidence sources for meeting this standard include:

- evidence that the quality of initial education and training is evaluated in an integrated way. By integrated we mean an evaluation that looks at all aspects of provision.
- evidence that MPharm degrees are developed with input from external stakeholders, including patients and the public;
- quality monitoring data from universities;
- quality monitoring data from placement providers and other practice learning sources;
• our accreditation reports and annual school surveys;
• achievement in the Registration Assessment;
• quality monitoring data from pre-registration providers;
• pre-registration tutor evaluations of trainees;
• trainee evaluations of pre-registration tutors;
• premises inspection reports.

2.3 The required evidence includes:

• entry requirements and evidence of how they support the aims and philosophy of the programme;
• outcomes of integrated evaluations of initial education and training;
• views of external stakeholders, including patients and the public, and evidence demonstrating how their views have informed course design and delivery;
• outcomes of evaluations of the quality of teaching, learning and assessment;
• outcomes of evaluations of resources and capacity;
• outcomes of the evaluations of the quality of placements and other practice learning opportunities;
• outcomes of appraisal and feedback systems for students and trainees;
• outcomes of achievement in the Registration Assessment;
• outcomes of pre-registration tutor evaluations of trainees;
• outcomes of trainee evaluations of tutors.

Note that the evidence above is likely to be included in evaluation processes already in place (and existing processes may well deal with more than one category of evidence).

Guidance on meeting this standard

2.4 Evaluation strategies must evidence 2.3 above.

2.5 Evaluation should include action which is agreed and monitored.
Pre-requisites for meeting this standard

2.6 University quality assurance processes are robust, rigorous and transparent.

2.7 Universities are open with the GPhC about matters affecting an accredited MPharm degree. It is a requirement of the Pharmacy Order that course providers assist the GPhC in its work by providing information on request.

2.8 Universities raise relevant issues proactively with the GPhC.
Standard 3 – Equality, diversity and fairness

Standard

3. Initial pharmacy education and training must be based on principles of equality, diversity and fairness. It must meet the requirements of all relevant legislation.

Information to meet this standard

3.1 Systems and policies for capturing equality and diversity data. Concerns should be documented, addressed and disseminated.

3.2 Strategies for staff training in equality and diversity.

Evidence required for meeting this standard

3.3 Evidence that initial education and training deals with equality, diversity and fairness issues in an informed way.

3.4 Evidence that concerns have been addressed.

3.5 Evidence that staff, students and trainees have been trained in equality and diversity issues and are updated as necessary.

Comment [DD8]: Addition – MPC, E & D training shouldn’t be static

Guidance on meeting this standard

3.5 This standard is intended to ensure that applicants, both students and trainees, are not treated unfairly on grounds of:

- gender;
- race;
- social background;
- disability;
- religion;
- sexual orientation;
- other forms of discrimination.

The requirements of the Equality Act (2010) should be taken into account in this regard.

3.6 Equality and diversity awareness should be an integral part of initial education and training.
Standard 4 - Selection of students and trainees

Standard

4. Selection processes must be open, fair and comply with relevant legislation. Processes must ensure students and trainees are fit to practise as students or trainees at the point of selection. Selection includes recruitment and admissions.

Criteria to meet this standard

4.1 Selection processes must give applicants the guidance they need to make an informed application.

4.2 Selection criteria must be explicit. They should include:

• meeting academic and professional entry requirements;
• meeting English language requirements appropriate to MPharm degree study. Guidelines issued by English language testing bodies should be followed to ensure that admissions language requirements are appropriate;
• meeting numeracy requirements;
• taking account of good character checks, such as Criminal Records Bureau (CRB)/Disclosure Scotland checks;
• taking account of health checks;
• recognising prior learning, where that is appropriate.

4.3 Selectors should apply selection criteria fairly. They should be trained to do this. Training should include equality and diversity awareness.

Evidence required for meeting this standard

4.4 Evidence that selection processes and procedures comply with relevant legislation.

4.5 Evidence that the criteria in 4.2 are being applied.

4.6 Evidence that staff involved in selection have been trained appropriately and are aware of relevant legislative requirements.
Guidance on meeting this standard

4.7 All selection requirements should be set out clearly in guidance made available to applicants. Applicants must know what will happen to them during selection, including what health and good character checks will be made.

4.8 Guidance should include information about additional costs associated with making an application.

4.9 It must be made clear to students and trainees that the GPhC will carry out its own health, good character and identity checks before registering an applicant. It must be made clear to students that these checks relate to registration and are additional to checks made by universities and employers. It must be made clear to students and trainees that the GPhC may not register a student if a check is failed, even if they have passed previous checks.

4.10 It must be made clear to students and trainees that the GPhC will not offer prospective registration advice.

4.11 It must be made clear to students and trainees that an applicant can appeal against a registration refusal and that appeals must be made to the GPhC’s Appeals Committee.

Standard 5 – Curriculum delivery and the student experience

Standard
5. The curriculum for MPharm degrees and the pre-registration scheme must deliver the outcomes in standard 10. Most importantly, curricula must ensure students and trainees practise safely and effectively. To ensure this, pass criteria must describe safe and effective practice.

Criteria to meet this standard

5.1 Curricula must be integrated. This does not mean necessarily that initial education and training must be delivered as a 5-year MPharm degree with integrated pre-registration training but that the component parts of the sciences and training ensure that the required qualifications and the links are in place.

5.2 Curricula must be progressive, dealing with issues in an increasingly more complex way until the right level of understanding is reached.

(Harden RM and Stamper N (1999) What is a spiral curriculum? Medical Teacher. 21: 141–3)

5.2 An MPharm degree must be delivered in an environment which places study in a professional and academic context and requires students to conduct themselves professionally. Pre-registration must be delivered in a professional environment which requires trainees to conduct themselves professionally.
5.3 An MPharm must be delivered in an environment informed by research. This means that whether or not all staff are engaged in research, their teaching must be informed by current research.

5.4 An MPharm degree teaching and learning strategy must set out how students will achieve the learning outcomes in standard 10. Learning opportunities must be structured to provide
- an integrated experience of relevant science and pharmacy practice;
- a balance of theory and practice;
- independent learning skills.

5.5 The MPharm degree curriculum must include practical experience of working with patients, carers and other healthcare professionals. Practical experience should increase year on year. We are not suggesting that off-site placement visits are the only way to achieve this. Schools should articulate their strategy for meeting this criterion, which may include off-site placement visits, using patients, carers and other healthcare professionals in-class and simulations.

5.6 There must be a clear assessment strategy for the MPharm degree. Assessment methods must measure the learning outcomes in Standard 10.

5.7 The MPharm degree assessment strategy should include:
- diagnostic assessments;
- formative assessments;
- summative assessments;
- timely feedback.

5.8 Academic regulations must be appropriate for a degree that is both academic and professional and may lead to further professional training. As a general principle, all assessments, including components, must be passed. This means that condonation, compensation, trailing, extended resit opportunities and other remedial measures should be extremely limited, if they are permitted at all. MPharm degree academic regulations may be more stringent than university norms. This may include higher than usual pass marks for assessments demonstrating knowledge and skills essential to safe and effective pharmacy practice.

5.9 Marking criteria must be used for all assessments and all pass criteria must reflect safe and effective practice.

5.10 Patient safety must be paramount in assessments: any evidence of an assessment demonstrating unsafe practice must result in failure.
5.11 A pre-registration training plan must describe how the learning outcomes for pre-registration will be delivered.

5.12 A pre-registration training plan must describe all assessments, including tutor evaluations and tutor sign-offs.

Evidence required for meeting this standard
5.13 Evidence sources will include:
   - MPharm degree teaching and learning strategies;
   - MPharm degree assessment strategies;
   - pharmacy research strategies;
   - assessment criteria;
   - academic regulations;
   - MPharm degree external examiners’ reports;
   - reports of MPharm degree accreditation visits;
   - internal university quality reports;
   - evaluation and feedback from students, trainees and tutors;
   - national peer reviewed research assessment exercises;
   - Registration Examination progression data;
   - reports of pre-registration training site visits;
   - pre-registration training plans.

5.14 Required evidence will include:
   - evidence of the impact of teaching and learning strategies on course delivery and the student experience;
   - evidence of the impact of assessment strategies on course delivery and the student experience;
   - evidence of the impact of current research on course design;
   - evidence that assessment pass criteria reflects safe and effective practice;
   - evidence that issues raised during accreditation visits have been addressed;
   - evidence that evaluation and feedback from all sources has been acted on;
• evidence that reasonable adjustments have been made to course/training delivery for students/trainees;
• evidence that attrition rates are understood;
• evidence that Registration Assessment progression data has been used to inform course design;
• evidence that pre-registration progression data has been used to inform course design.

Note that the evidence above is likely to be included in evaluation processes already in place (and existing processes may well deal with more than one category of evidence).

Guidance on meeting this standard

5.15 Assessment and feedback systems should be embedded in all five years of initial education and training.
5.16 There should be a range of teaching and learning methods to deliver the outcomes in Standard 10.
5.17 There should be a range of assessment methods to test all the outcomes in Standard 10.
5.18 Links between diagnostic, formative and summative assessments must be made clear to students and trainees.
5.19 Links between assessments and feedback must be made clear. Feedback must be given in time for it to be used effectively.
5.20 There should be deadlines for assessments to be marked and for feedback to be given. Action should be taken if deadlines are not met.
5.21 Where appropriate, reasonable adjustments must be made to curriculum delivery to help students and trainees with specific needs meet learning outcomes. Teaching, learning and assessment can be modified for this purpose but learning outcomes cannot.

Standard 6 – Support and development for students and trainees

Standard

6. Students and trainees must be supported to develop as learners and professionals during their initial education and training.

Criteria to meet this standard
6.1 A range of mechanisms should be in place to support students and trainees to develop as learners and professionals.

Evidence required for meeting this standard

6.2 Evidence of appropriate personal and professional development, such as:
   - student CPD portfolios;
   - trainee CPD portfolios;
   - tutor evaluations of trainees;
   - trainee evaluations of tutors.

Guidance on meeting this standard

6.3 Students and trainees must work with a range of academic and professional role models. The range must include:
   - academic staff in pharmacy, including practice staff, scientists, researchers and support staff;
   - tutors;
   - other healthcare professionals.

6.4 Students must have access to support for their academic and general welfare needs. Support must be readily available to students. If students are working off-site or trainees are working away from their normal pre-registration training premises, appropriate support mechanisms must be in place.

6.5 Students and trainees should have access to career advice.

6.6 If it is no longer possible for students to continue on an MPharm, they should be told what other
options are available to them by their school of pharmacy, in particular if they are able to transfer to other, non-accredited courses such as a Certificate, Diploma or BSc.

6.7 If it is no longer possible for a trainee to continue in the pre-registration scheme, they should be told what options are available to them.

Standard 7 — Support and development for academic staff and pre-registration tutors

Standard

7. Anyone delivering initial education and training should be supported to develop in their roles.

Criteria to meet this standard

7.1 A range of mechanisms should be in place to support anyone delivering initial education and training to develop in their role.
7.2 Induction programmes are provided for tutors and university staff as appropriate. This should include induction programmes for non-pharmacists working on MPharm degrees.

7.3 Everyone involved in delivering the curriculum should have:
   - effective supervision;
   - an appropriate and realistic workload;
   - effective personal support;
   - mentoring;
   - time to learn; and
   - continuing professional development opportunities.

7.4 Tutors have an identified source of peer support.

Evidence required for meeting this standard

7.5 Evidence that:
   - staff appraisal systems address performance issues (anonymised);
   - staff development systems affect course delivery.

Guidance on meeting this standard

7.6 Staff appraisal schemes should take account of the needs of all categories of staff, including practice staff and part-time staff.

7.7 Staff development should be in place for non-pharmacist staff to help them understand how their expertise contributes to the initial education and training of pharmacists and how it can best be delivered in a pharmaceutical context.
Standard 8 – Management of initial education and training

Standard

8. Initial pharmacist education and training must be planned and maintained through transparent processes which must show who is responsible for what at each stage.

Criteria to meet this standard

8.1 All education and training will be supported by a defined management plan with:

- a schedule of responsibilities;
- defined structures and processes to manage the delivery of education and training.

Evidence required for meeting this standard

8.2 Evidence sources should include:

- management plans. For students this will be course documents. For trainees it will be at least a Pre-registration Training Plan;
- evidence of working arrangements between stakeholders, such as clear plans and service level agreements for certain activities;
- university quality monitoring processes and the outcomes of these processes;
- pre-registration tutor evaluations of trainees and trainee evaluations of tutors.
8.3 Required evidence includes:

- outcomes of university quality management process affecting pharmacy;
- service level agreements or other agreements between stakeholders;
- evaluations of the relationship between stakeholders and actions taken to address issues;
- evaluations of pre-registration training.

Guidance on meeting this standard

8.4 Systems and structures should be in place to manage the learning of students in the academic environment. They must take account of:

- access to and availability of suitable learning facilities;
- the balance between taught components, directed learning and student/trainee self-study;
- student attendance, particularly minimum requirements and what is compulsory;
- mechanisms to ensure structured, off-site learning is quality assured and linked to specified areas of the curriculum and learning outcomes. This must include the quality assurance of placements and placement staff.

8.5 Systems and structures should be in place to manage the learning of students and trainees in practice. They must take account of:

- placement capacity and sustainability;
- allocation of students to placements;
- management of student progress through placements;
- mechanisms for data collection to support audit of placements;
- access to and availability of suitable learning facilities;
- managing and monitoring attendance;
- ways in which students and trainees can communicate with tutors and staff when they are off-site.
Standard 9 – Resources and capacity

9. Resources and capacity are sufficient to deliver learning outcomes.

Criteria to meet this standard

9.1 There must be:

- robust and transparent mechanisms for securing an appropriate level of resource for delivering an accreditable MPharm degree.
- sufficient staff from relevant disciplines to deliver the curriculum to students and trainees. Staff must be appropriately qualified and experienced. The staffing profile must include:
  - sufficient numbers of pharmacists – registrants of the GPhC - with experience of teaching in higher education to ensure that an MPharm degree can produce students equipped to enter pharmacist pre-registration training in Great Britain;
  - sufficient numbers of pharmacists to act as tutors and professional mentors at university and in pre-registration. Not all personal tutors must be pharmacists;
  - pharmacists who are leaders in the profession, the school and in their university, who can influence school and university policy relevant to pharmacy;
  - non-pharmacist academics who can influence school and university policy relevant to pharmacy;
- staff who are sufficiently experienced to supervise research. It would be unusual for anyone to supervise research at a particular academic level unless they had previously researched to that level or beyond. New research supervisors must be mentored and signed off as being fit to supervise after a period of mentoring;
- science academics who understand the relevance of their discipline to pharmacy and deliver their area of expertise in a pharmaceutical context;
- academic pharmacists and other experienced MPharm degree staff who act as mentors to non-pharmacist colleagues.

- pre-registration tutors who meet the GPhC’s standards for pre-registration tutors;
- career pathways in universities for all staff teaching on MPharm degrees, including pathways for practice staff;
- clear lines of authority and responsibility for the strategic organisation and day-to-day management of placements;
- training and ongoing support for all non-pharmacists involved in the delivery of MPharm degrees which must:
  - help them understand the relevant of their work to pharmacy; and
  - how to deliver their area of expertise in a pharmaceutical context.
- appropriate learning resources;
- accommodation and facilities that are fit for purpose;
- pre-registration premises which meet the GPhC’s standards for pre-registration premises.

Evidence required for meeting this standard

9.2 Required evidence will include:
- evidence that there are mechanisms for securing appropriate levels of resource sufficient to deliver an MPharm degree to the required standard;
- evidence that the staffing profile can support the delivery of the course and the student experience;
- evidence that the staffing profile includes pharmacists who are leaders in the profession, the school and in their university, who can influence school and university policy relevant to pharmacy;
- evidence that the staffing profile includes non-pharmacists who can influence schools and university policy relevant to pharmacy;
- career structures for all categories of staff, including practice staff;
- evidence that the staffing profile includes a critical mass of pharmacists – registrants of the GPhC – sufficient to ensure the course is focused on the profession of pharmacy in Great Britain;
- evidence that all staff supervising student research are appropriately qualified to do so. This must include criteria for eligibility to supervise research at the required level;
- evidence that there is recognised training and ongoing support for all non-pharmacist staff to ensure their contribution to an accredited course is orientated to pharmacy;
- evidence that learning resources are fit for purpose;
- evidence that accommodation and facilities are fit for purpose;
- evidence that pre-registration tutors and premises meet the GPhC’s standards.

Guidance on meeting this standard

9.3 Initial education and training providers exercise an appropriate level of autonomy over pharmacy resources to deliver an MPharm degree to the required standard and in an appropriate learning environment. The precise nature of the autonomy of pharmacy and its senior managers will be determined by the institutional context in which pharmacy finds itself. However, whatever the context, there must be robust and transparent ways of securing resources for pharmacy.

9.4 Initial education and training environments must support students and trainees achieving the outcomes in Standard 10.

9.5 These standards describe the types of staff required to deliver an MPharm degree and pre-registration training. All pre-registration tutors must be pharmacists and some MPharm degree staff must be pharmacists. It is important to remember what the legal definition of a pharmacist is:

‘A person practices as a pharmacist or pharmacy technician if, whilst acting in the capacity of or purporting to be a pharmacist or pharmacy technician, that person undertakes any work or gives any advice in relation to the preparation, assembly, dispensing, sale, supply or use of medicines, the science of medicines, the practice of pharmacy or the provision of healthcare.’ (Pharmacy Order 2010)
In a university context, this definition is not restricted to staff who teach pharmacy practice but includes staff involved in 'the provision of healthcare' and 'the science of medicines' among other things. This definition means that staff other than teacher-practitioners or pharmacy practice staff may be registered as pharmacists.

Note: The GPhC does not have a non-practising registration category.

Standard 10 – Learning outcomes

Context

To be safe and effective, the practice of pharmacy must be underpinned by relevant and up-to-date science. Sound science is the basis of effective pharmacy.

Students and trainees must be able to
- study and train safely and effectively;
- study and train ethically and lawfully;
- understand and apply biomedical and pharmaceutical science principles, method and knowledge;
- understand and apply psychological and social science principles, method and knowledge; and
- understand and apply population and improvement science principles, method and knowledge.

The outcomes defined in this section are practical and describe safe and effective pharmacy practice. The practice of pharmacy requires pharmacists to make decisions in complex and
unpredictable situations, sometimes in the absence of complete data. Pharmacists need to communicate with patients and the public clearly; often they will need to explain complicated ideas in a way that is understandable to patients and carers. Equally, pharmacists need to understand the complexities of patients' circumstances insofar as they are relevant to their medicines use or other behaviours relevant to personal health & wellbeing.

As professionals, pharmacists must act on their own initiative and take personal responsibility for what they do. Pharmacists need to have the independent learning ability required for continuing professional development in order to maintain a critical awareness of current practice. To prepare students for this, the initial education and training of pharmacists is at master's level (as defined by the UK's Quality Assurance Agency).

The initial education and training of pharmacists is extensive and rigorous. After five years it is realistic to expect a person to be competent but not yet proficient or expert.

Recent registrants develop their core competencies both during and then beyond their initial educational experience. The first few years after graduation are crucial in developing the personal patterns of professional practice central to being a safe, independent and proficient practitioner.

**Describing and assessing outcomes**

The outcome levels in standard 10 have been derived from a competence and assessment hierarchy, known as Miller's triangle (Miller GE. The assessment of clinical skills / competence / performance. Acad Med 1990; 65:563-7). Although Miller developed the triangle for clinical work, it can be applied to science too.
As what is being assessed at each of the four levels is different, the assessment types associated with the levels are different too, although there will be some overlap.

Level 1 – Knows. Knowledge that may be applied in the future to demonstrate competence.
Assessments may include essays, oral examinations and MCQs.
Level 2 - Knows how. Context-based tests - knows how to use knowledge and skills.
Assessments may include essays, oral examinations, MCQs, and laboratory books.
Level 3 - Shows how. A student or trainee is able to demonstrate that they can perform in a simulated environment or in real life. Assessments may include Objective Structured Clinical Examinations (OSCEs), simulated patient assessments, designing, conducting and reporting an experiment, dispensing tests and taking a patient history.
Level 4 – Does. Acting independently and consistently in the complex situation of an everyday or familiar context. Evidence for this level is showing in this context that one is able to demonstrate the learning outcomes in a complex everyday situation repeatedly and reliably.
Assessments may include OSCEs, taking a patient history and a trainee demonstrating things in the Pre-registration Performance Standards repeatedly, accurately and safely. The trainee needs to be observed doing these things by their tutor and others.

Note that these levels do not equate to years of study.

Teaching and learning

A curriculum should not be formulaic and should include a variety of teaching and learning methods. Typically, teaching and learning methods should result in:
learning based on experience that provides clinical education in a range of practices and procedures;
learning based on experience that provides scientific education in a range of practices and procedures;
learning based on experience that provides education in inter-professional practices and procedures with other healthcare professionals;
learning that enables the demonstration of behaviours, attitudes and values set out in the GPhC’s Code of conduct for pharmacy students and Standards of conduct, ethics and performance; learning including research and research methods to ensure students meet the research requirements for master’s degrees in the QAA’s qualifications frameworks; learning that integrates theory and practice opportunities for developing the skills students/trainees need to become self-directed learners; opportunities to reflect on learning and practice and to discuss issues with staff and peers. This should include activities like pharmacist continuing professional development (CPD); and opportunities for students to develop specialist knowledge, for example veterinary/industrial pharmacy or recent advances in science relevant to pharmacy.

MPharm degree students may study abroad for specified periods if the period abroad is mapped onto relevant learning outcomes and the school knows what a student will be doing in advance. The maximum period of study overseas permissible is two years. Pre-registration trainee pharmacists may spend up to 13 weeks of their 52 weeks of training in another EU member state.

The link between teaching, learning and assessment
The link between teaching and learning and assessment must be explicit. Assessment must complement teaching and learning. Assessment must test competence and the achievement of the learning outcomes in this standard. Ensuring this will be a central feature of our quality assurance processes.

Devolution
The GPhC’s register is GB-wide. By country of residence the split is 80%+ in England, 10% in Scotland, 5% in Wales, with the remainder overseas. As students may work in any country, they must be made aware of the similarities and differences in the provision of healthcare in the countries of Great Britain.
Learning outcomes for the initial education and training of pharmacists

10.1 Expectations of a pharmacy professional

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>MPharm</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Pre-registration learning outcomes are for reference only if a 4-year MPharm is being delivered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Recognise ethical dilemmas &amp; respond in accordance with relevant codes of conduct</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>2. Recognise the duty to take action if a colleague’s health, performance or conduct is putting patients or public at risk</td>
<td>Knows how</td>
<td>Knows how</td>
</tr>
<tr>
<td>3. Recognise personal health needs, consult and follow the advice of a suitably qualified professional, and protect patients or public from any risk posed by personal health</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>4. Apply the principles of clinical governance in practice</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>5. Demonstrate how the science of pharmacy is applied in the design and development of medicines and devices</td>
<td>Shows how</td>
<td>Knows how</td>
</tr>
<tr>
<td>6. Contribute to the education and training of other members of the team, including peer review and assessment</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>7. Contribute to the development of other members of the team through coaching and feedback</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>8. Engage in multidisciplinary team working</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>9. Respond appropriately to medical emergencies, including provision of first aid</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

10.2 The skills required in practice

Implementing health policy

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>MPharm</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Promote healthy lifestyles by facilitating access to and understanding of health promotion information</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>2. Access &amp; critically evaluate evidence to support safe, rational &amp; cost effective use of medicines</td>
<td>Shows how</td>
<td>Knows how</td>
</tr>
<tr>
<td>3. Use the evidence base to review current practice</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td></td>
<td>Learning outcome</td>
<td>MPharm</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>4</td>
<td>Apply knowledge of current pharmacy-related policy to improve health outcomes</td>
<td>Knows how</td>
</tr>
<tr>
<td>5</td>
<td>Collaborate with patients, the public and other healthcare professionals to improve patient outcomes</td>
<td>Knows how</td>
</tr>
<tr>
<td>6</td>
<td>Play an active role with public and professional groups to promote improved health outcomes</td>
<td>Knows how</td>
</tr>
<tr>
<td>7</td>
<td>Contribute to research &amp; development activities to improve health outcomes</td>
<td>Knows how</td>
</tr>
<tr>
<td>8</td>
<td>Provide evidence-based medicines information</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

Validates therapeutic approaches and supplies prescribed and over the counter medicines

<table>
<thead>
<tr>
<th></th>
<th>Learning outcome</th>
<th>MPharm</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify and employ the appropriate diagnostic or physiological testing techniques in order to promote health</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>2</td>
<td>Identify inappropriate health behaviours and recommend suitable approaches to interventions</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>3</td>
<td>Instruct patients in the safe and effective use of their medicines and devices</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>4</td>
<td>Analyse prescriptions for validity and clarity</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>5</td>
<td>Clinically evaluate the appropriateness of prescribed medicines</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>6</td>
<td>Provide, monitor and modify prescribed treatment to maximise health outcomes</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>7</td>
<td>Communicate with patients about their prescribed treatment</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>8</td>
<td>Optimise treatment for individual patient needs in collaboration with the prescriber</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>9</td>
<td>Record, maintain and store patient data</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>10</td>
<td>Supply medicines safely and efficiently, consistently within legal requirements and best professional practice. NB This should be demonstrated in relation to both human and veterinary medicines.</td>
<td>Shows how</td>
<td>Does</td>
</tr>
</tbody>
</table>

Ensure safe and effective systems are in place to manage risk inherent in the practice of pharmacy and the delivery of pharmaceutical services
<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>MPharm</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensure quality of ingredients to produce medicines and products</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>2. Apply pharmaceutical principles to the formulation, preparation and packaging of products</td>
<td>Shows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>3. Use pharmaceutical calculations to verify the safety of doses and administration rates</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>4. Develop quality management systems including maintaining appropriate records</td>
<td>Shows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>5. Manage and maintain quality management systems including maintaining appropriate records</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>6. Procure and store medicines and other pharmaceutical products working within a quality assurance framework</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>7. Distribute medicines safely, legally and effectively</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>8. Dispose of medicines safely, legally and effectively</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>9. Manage resources in order to ensure work flow and minimise risk in the workplace</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>10. Take personal responsibility for health and safety</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>11. Work effectively within teams to ensure safe and effective systems are being followed</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>12. Ensure the application of appropriate infection control measures</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>13. Supervise others involved in service delivery</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>14. Identify, report and prevent errors and unsafe practice</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>15. Procure, store and dispense and supply veterinary medicines safely and legally</td>
<td>Knows how</td>
<td>Knows how</td>
</tr>
</tbody>
</table>

Comment [DD21]: Reworded for clarity – MPC suggested wording

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>MPharm</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish and maintain patient relationships while identifying patients’ desired health outcomes and priorities</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>2. Obtain and record relevant patient medical, social and family history</td>
<td>Shows how</td>
<td>Does</td>
</tr>
</tbody>
</table>
### Learning outcome

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>MPharm</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate the characteristics of a prospective professional pharmacist as set out in relevant codes of conduct and behaviour</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>2. Reflect on personal and professional approaches to practice</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>3. Create and implement a personal development plan</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>4. Review and reflect on evidence to monitor performance and revise professional development plan</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>5. Participate in audit and in implementing recommendations</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>6. Contribute to identifying learning and development needs of team members</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>7. Contribute to the development and support of individuals and teams</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>8. Anticipate and lead change</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

### Appendix 1 – Indicative syllabus

A1.1 How medicines work

- Therapeutics
- Routes of administration
- New therapeutic advances
- Infection control
- Complementary therapies

34
Clinical therapeutic uses of drugs

Applied Physical, Chemical and Biological sciences
(Bio) Analytical principles and methods
pharmaceutical analytical instrumentation
scope and limitations of analytical techniques
advanced instrumental methods
drug identification
Drug design and discovery
drug targets
structure:activity relationships
molecular modelling
Cell and molecular biology
prokaryotic and eukaryotic cell structure and function
major cell components
cell signalling
membrane transport
cell biochemistry:biosynthetics and metabolism
cellular genetics
Microbiology
classification and identification
bacteria, fungi, viruses, protozoa, helminths
replication
pathogenicity and virulence
zoonoses
Immunology
transplantation
vaccination
diagnostics
Pharmaceutical chemistry
chemical structure, bonding and nomenclature
chemical functional groups and reactivity
drug synthesis
thermodynamics and chemical kinetics
physicochemical properties of drug molecules
sources and purification of medicinal substances, including natural products

Pharmacology, pharmacokinetics & pharmacodynamics
Contraindications, adverse reactions and drug interactions
Absorption, distribution, metabolism and excretion (ADME)
Pharmacokinetic modeling
Bioavailability and bioequivalence
Prediction of drug properties
Pharmacogenetics and pharmacogenomics
Drug and substance misuse
Clinical toxicology and drug-over-exposure
Molecular basis of drug action
Metabolism
Pharmaceutical technology including manufacturing & engineering science
  Biotechnology
  biotechnological use of microorganisms
  recombinant DNA technology
  transgenic animals
  tissue engineering
  Manufacturing methods
  Quality assurance processes, including raw materials and products
  Sterilisation and asepsis
  Environmental control in manufacturing

  Formulation and material science
  Materials used in formulations and devices
    Dosage forms
    Formulation principles
  Biopharmaceutics, developmental pharmaceutics, pre-formulation and formulation studies
    Design and standardisation of medicines
    Microbiological contamination
    Contamination control
    Product stability
    Medical devices

A1.2 How people work

  Normal & abnormal structure & function
    Nutrition
  Anatomy and physiology
  physiological regulation and homeostasis
  neural communication and control
  clinical immunology: autoimmune disease; hypersensitivity reactions
  Pathology
  Infectious diseases and infective processes
  Wound repair
  Sociology
  Social and behavioural science
  Drug misuse
  Drugs in sport

  Health psychology
  Health promotion
  Disease prevention
  Behavioural medicine

  Objective diagnosis

  Differential diagnosis
Symptom recognition
Diagnostic tests

Epidemiology

Aetiology and epidemiology of (major) diseases

A1.3 How systems work

Healthcare management

Public health
Organisations: National Health Service (NHS), Department of Health (DH), governmental priorities
Other professionals
Health care systems
Veterinary pharmacy

Evidence-based practice
Health information systems/ resources
Health policy and (pharmaco)economics
Health-related quality of life
Pharmacovigilance

Professional regulation
Legislation
Professional ethics and fitness to practise
Sale and supply of medicines
CPD
Political and legal framework

Medicines regulation
Evaluation and regulation of new drugs and medicines
Pharmacopoeial specifications and biological standards
Medicines licensing
Product quality, safety and efficacy
The supply chain
Packaging, labelling and patient information

Clinical governance
Standard Operating Procedures (SOPs)
Research methodology / research ethics
Risk & quality management
Good manufacturing/dispensing practice
Good clinical practice
Health policy, clinical and science research methods

Clinical management
Disease management
Chronic medicines management
Medicines use review
Care planning
Therapeutic drug monitoring

Workplace Regulation
Health & Safety
Sexual boundaries
Independent Safeguarding Authority
Data protection
Freedom of Information Act (FOIA)
Consumer protection, including complaints procedures

A1.4 Core and transferable skills

Professionalism
Research (including research methods)

Critical appraisal
Audit and learning from errors
Analysis of evidence
Evaluation of the literature

Problem solving
Study skills
Team-working skills
Integrating knowledge from multiple sources
Clinical decision making
Leadership skills

Accurate record keeping

Reflective practice [including continuing professional development]

Effective communication

Interpersonal skills

Medical terminology

Interpret & interrogate clinical/scientific data

Analyse & use numerical data

Pharmaceutical numeracy

Literature searching

A1.5 Attitudes and values

See the Code of conduct for pharmacy students (2010) and Standards of conduct, ethics and performance (2010)
Appendix 2 - European requirements for the initial education and training of pharmacists

The European Community's Directive 2005/36/EC on the European Parliament and of the Council on the recognition of professional qualifications includes requirements for the initial education and training of pharmacists. The requirements constitute the Minimum Training Requirement (MTR). They include

Section 7 Pharmacist

Article 44 Training as a pharmacist

2. Evidence of formal qualifications as a pharmacist shall attest to training of at least five years' duration, including at least:

(a) four years of full-time theoretical and practical training at a university or at a higher institute of a level recognised as equivalent, or under the supervision of a university;

(b) six-month traineeship in a pharmacy which is open to the public or in a hospital, under the supervision of that hospital's pharmaceutical department.

3. Training for pharmacists shall provide an assurance that the person concerned has acquired the following knowledge and skills:

(a) adequate knowledge of medicines and the substances used in the manufacture of medicines;

(b) adequate knowledge of pharmaceutical technology and the physical, chemical, biological and microbiological testing of medicinal products;

(c) adequate knowledge of the metabolism and the effects of medicinal products and of the action of toxic substances, and of the use of medicinal products;
(d) adequate knowledge to evaluate scientific data concerning medicines in order to be able to supply appropriate information on the basis of this knowledge;

(e) adequate knowledge of the legal and other requirements associated with the pursuit of pharmacy.

Article 45 Pursuit of the professional activities of a pharmacist

...

2. The Member States shall ensure that the holders of evidence of formal qualifications in pharmacy at university level or a level deemed to be equivalent, which satisfies the provisions of Article 44, are able to gain access to and pursue at least the following activities, subject to the requirement, where appropriate, of supplementary professional experience:

(a) preparation of the pharmaceutical form of medicinal products;

(b) manufacture and testing of medicinal products;

(c) testing of medicinal products in a laboratory for the testing of medicinal products;

(d) storage, preservation and distribution of medicinal products at the wholesale stage;

(e) preparation, testing, storage and supply of medicinal products in pharmacies open to the public;

(f) preparation, testing, storage and dispensing of medicinal products in hospitals;

(g) provision of information and advice on medicinal products.

...

The syllabus is at V.6. Pharmacist 5.6.1. Course of training for pharmacists.
Appendix 3 - National & European requirements for master's level qualifications

The United Kingdom is a signatory to the Bologna Declaration. The Declaration produced a number of common Actions which have been designed to harmonize higher education qualifications across Europe. Because it is a signatory, the United Kingdom has agreed to operate a degree system including bachelor, master's and doctoral qualifications.

MPharm degrees are compliant with the requirements of:

- the Framework for Qualifications in the European Higher Education Area;
- the UK Quality Assurance Agency's Framework for Higher Education Qualifications (covering England, Wales and Northern Ireland); and
- the Scottish Credit and Qualifications Framework Partnership's Scottish Credit and Qualifications Framework.

QAA Framework for Higher Education Qualifications - Descriptor for a higher education qualification at level 7 (Master's degrees)

The descriptor provided for this level of the framework is for any master's degree which should meet the descriptor in full. Master's degrees are awarded to students who have demonstrated:

- a systematic understanding of knowledge, and a critical awareness of current problems and/or new insights, much of which is at, or informed by, the forefront of their academic discipline, field of study or area of professional practice;
- a comprehensive understanding of techniques applicable to their own research or advanced scholarship;
- originality in the application of knowledge, together with a practical understanding of how established techniques of research and enquiry are used to create and interpret knowledge in the discipline;
- conceptual understanding that enables the student:
  - to evaluate critically current research and advanced scholarship in the discipline;
  - to evaluate methodologies and develop critiques of them and, where appropriate, propose new hypotheses.
Typically, holders of the qualification will be able to:

deal with complex issues both systematically and creatively, make sound judgements in
the absence of complete data, and communicate their conclusions clearly to specialist
and non-specialist audiences;
demonstrate self-direction and originality in tackling and solving problems, and act
autonomously in planning and implementing tasks at a professional or equivalent level;
continue to advance their knowledge and understanding, and to develop new skills to a
high level.

And holders will have
the qualities and transferable skills necessary for employment requiring:

- the exercise of initiative and personal responsibility;
- decision-making in complex and unpredictable situations;
- the independent learning ability required for continuing professional development.

Appendix 4 - Sites for pharmacist pre-registration training

Pre-registration training may take place on any site approved by the GPhC. This includes:
• community pharmacies;
• NHS hospital pharmacies;
• primary care trusts;
• schools of pharmacy with an accredited MPharm degree;
• the pharmaceutical Industry;
• prison pharmacies;
• mental health trusts;
• private hospitals;
• registered pharmacies engaged solely in the supply of animal and agricultural products.

At least 26 weeks of the 52 weeks of pre-registration training must be patient-facing.

Further information

This document has been written for professional educators and trainers. There are other documents explaining these standards and requirements which have been written for different audiences.

If you are a pre-registration trainee or have applied to enter the pre-registration scheme, the most useful document for you is the Pre-registration Training Manual for Trainees. The manual contains the standards you have to meet and also information on the Registration Assessment.
If you are a pre-registration tutor, or are thinking of applying to become a tutor, the most useful document for you is the Pre-registration Training Manual for Tutors. It tells you what you have to do as a tutor and how to support a trainee.

You can find these documents at www.pharmacyregulation.org.

If you would like to speak to someone about the pre-registration scheme or the Registration Examination contact prerreg@pharmacyregulation.org

Other standards and guidance

We have published a document for non-EEA pharmacists wanting to register in Great Britain called Education and training standards for non-EEA pharmacists wanting to register in Great Britain.

Once registered, pharmacy professionals must meet our Standards of conduct, ethics and performance and Standards for continuing professional development.

You can find these documents at www.pharmacyregulation.org.

Reference documents

Accreditation and Recognition Manual (GPhC, 2011; in preparation)

Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals (Council for Healthcare Regulatory Excellence (CHRE))

Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practice panels (CHRE)

Code of Conduct for Pharmacy Students (General Pharmaceutical Council (GPhC), 2010)

Code of Practice for the assurance of academic quality and standards in higher education (Quality
Assurance Agency (QAA))


Fitness to Practise in Schools of Pharmacy: a Literature Review (Schafheutle et al on behalf of the RPSGB, 2009)

Framework for higher education qualifications in England, Wales and Northern Ireland (QAA, 2008)

Framework for Qualifications in the European Higher Education Area

From pharmacy education into pre-registration training (Willis, S. et al., Centre for Workforce Studies @ The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2007)

Good character assessment framework template (contact GPhC)

Guidance on Student Fitness to Practise Procedures in Schools of Pharmacy (GPhC, 2010)

Health assessment framework template (contact GPhC)

Healthcare Professional Education & Training: How does Pharmacy in Great Britain compare? (Wright, D. et al, University of East Anglia for the RPSGB, 2006)

Higher education credit framework for England: guidance on academic credit arrangements in higher education in England (QAA, 2008)

IELTS Guide for Stakeholders (International English Language Testing System (IELTS), 2009)

Institutional audit of higher education institutions in England and Northern Ireland, operational description (draft; QAA, 2010)

Learning about sexual boundaries between healthcare professionals and patients: a report on education and training (CHRE)

Learning from innovation in pharmacy education (PPRT, 2007)


MPharm Programmes: Where are we now? (Wilson, K et al, Aston University Pharmacy Practice Research Group, Pharmacy Practice Research Trust (PPRT), 2005)

MPharm Student Code of Conduct: a Literature Review (Schafheutle et al on behalf of the RPSGB, 2009)


Pharmacy in England, building on strengths – delivering the future (Department of Health/HM
Government, 2008)
The Pharmacy Order (Department of Health, 2010)

Pharmacy Undergraduate Students: Career Choices and Expectations across a Four-Year Programme
(Wilson, K. et al, the Aston University Pharmacy Practice Research Group, PPRT, 2006)

Pre-registration Performance Standards (in GPhC Pre-registration Trainee Workbook)

Pre-registration Trainee Workbook (GPhC, annual)

Pre-registration Tutor Workbook (GPhC, annual)

Registration Examination Syllabus (in Pre-registration Trainee Workbook)

Revised Performance Review Process and Standards (CHRE, 2010)

Scottish Credit and Qualifications Framework (Scottish Credit and Qualifications Framework Partnership,
http://www.scqf.org.uk/home/home.aspx)

Sexual boundary violations by health professionals – an overview of the published empirical literature
(CHRE)

Standards of conduct, ethics and performance (GPhC, 2010)

Standards of conduct, ethics and performance for pre-registration trainee pharmacists (GPhC, 2011)
Studying Pharmacy: who, when, how why? What next? (Willis, S. et al., Centre for Workforce Studies @
The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2006)

Work, employment and the early careers of cohort pharmacists (Willis, S. et al., Centre for Workforce
Studies @ The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2009)

Working lives of pre-registration trainees (Willis, S. et al., Centre for Workforce Studies @ The
Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2008)

Websites

General Pharmaceutical Council (GPhC): http://www.pharmacyregulation.org/

British Pharmaceutical Students’ Association (BPSA): http://www.bpsa.co.uk/


Council of University Heads of Pharmacy (CUHOP): http://www.cuhop.ac.uk/

European Commission/European Union (EC/EU): http://ec.europa.eu and document service at
http://eur-lex.europa.eu
International English Language Testing Service (IELTS): [http://www.ielts.org](http://www.ielts.org)

Modernising Pharmacy Careers (MPC):


Quality Assurance Agency (QAA): [http://www.qaa.ac.uk/](http://www.qaa.ac.uk/)

UK Border Agency (UKBA): [http://www.ukba.homeoffice.gov.uk/](http://www.ukba.homeoffice.gov.uk/)
Appendix B

Standards for the education and training of non-EEA pharmacists wanting to register in Great Britain

April 2011
Standards for the education and training of non-EEA pharmacists wanting to register in Great Britain

This document provides schools of pharmacy\(^1\) with the standards for the education and training of non-EEA pharmacists wanting to register in Great Britain.

The requirements for submitting a course for accreditation are in our accreditation and recognition manual which is published separately.

This document may also be of interest to prospective and current non-EEA pharmacists studying in Great Britain and those involved in the initial education and training of pharmacists, pharmacy professionals and members of the public.

---

\(^1\) The term ‘school of pharmacy’ is used throughout this document. It is used generically to describe the academic unit in a university with primary responsibility for delivering an accredited course. Depending on institutional structures a ‘school’ may be a school, department, division, faculty or other grouping. Whatever its name, for accreditation purposes a university must define the unit with primary responsibility for delivering an accredited course.
About us

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and pharmacy premises.

It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public, and in particular those members of the public who use or need the services of pharmacy professionals or the services provided at a registered pharmacy.

Our principal functions include:

- setting standards for conduct, ethics, proficiency, education and training, and continuing professional development (CPD);
- establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies;
- establishing fitness to practise requirements, monitoring pharmacy professionals' fitness to practise and dealing firmly and fairly with complaints;
- approving qualifications for pharmacists and pharmacy technicians;
- maintaining a register of pharmacists, pharmacy technicians and pharmacy premises.

We will aim to ensure that regulation is fair and proportionate – that is, in line with the level of risk posed to public health, safety and wellbeing – and not over-burdensome. We want it to be flexible enough to respond to the changing demands made of the profession and to allow for innovation at the same time as maintaining high quality practice.
Science into practice

In Standard 10 Learning Outcomes we make it very clear that sound science is the basis of effective, evidence-based pharmacy practice. We are aware that the outcomes in that standard are primarily clinical in nature, which reflects the needs of the majority of students. To make it amply clear that science is fundamental to the curriculum and to the student experience, we have included an indicative syllabus in which science figures significantly and unambiguously.

Requirements for the education and training of non-EEA pharmacists wanting to register in Great Britain

This document provides education and training standards for non-EEA pharmacists wanting to register in Great Britain.

Education and training requirements for non-EEA pharmacists wanting to register in Great Britain are:

- a one year Overseas Pharmacists’ Assessment Programme (OSPAP); then
- 52 weeks of pre-registration training; and
- our Registration Assessment (an examination); and
- successful health, good character and identity checks immediately prior to registration.

Normally, this route to registration must be completed in four years.

OSPAPs forming part of master’s degrees

OSPAPs are postgraduate diplomas at master’s level and can form part of full master’s degrees. In the case of pharmacy this would normally be an MSc. Where this is the case, only the OSPAP component of the degree will be accredited. Formal degree documents must make it clear that the degree includes an OSPAP, even if the postgraduate diploma is not awarded separately. Such degrees will be accepted as part of the education and training requirements for non-EEA pharmacists wanting to register in Great Britain.
Pre-requisites for studying on an OSPAP

The right to work and study in Great Britain
To study as an overseas student in Great Britain and to work as a pre-registration trainee pharmacist, a visa is required. Visa requirements are subject to change. The definitive source of information on current requirements is the UK Border Agency website.

The GPhC’s adjudication process
Before applying to an OSPAP provider, non-EEA pharmacists must be adjudicated (evaluated) by the GPhC. The adjudication process includes:

- the submission and scrutiny of required documents and
- health and good character assessments, such as CRB/Disclosure Scotland checks and equivalent checks in the applicant’s home country and

All applicants must have passed the Academic IELTS test with a score of 7.0 in all components in one sitting to be eligible for adjudication.

In certain circumstances, applicants will be interviewed. The circumstances are specified in Criteria for initial registration as a pharmacist (GPhC, 2010). They include:

- applicants whose primary qualification is not recognised as being at least Bachelor degree level by UK NARIC or
- applicants who submit their own evidence of qualifications, such as refugees

If an applicant passes the adjudication process they have two years to begin an OSPAP. After two years an applicant must reapply for adjudication if they have not begun an OSPAP but wish to do so.

The GPhC will set fees for adjudication.

---

2 The health and good character check will come into force on the 1st March 2011
Standard 1 - Patient and public safety

Standard

1. There must be clear procedures to address concerns about patient safety arising from pharmacy education and training. Concerns must be addressed immediately.

Criteria to meet this standard

1.1 There must be effective systems in place to ensure that students:

- do not jeopardise patient safety;
- only do tasks for which they are competent, sometimes under supervision;
- are monitored and assessed to ensure they always practise safely. Causes for concern should be addressed immediately;
- have access to support for health, conduct and academic issues;
- must not be awarded an accredited OSPAP if they might pose a risk to patients or the public;
- understand what is and what is not professional behaviour and are familiar with the GPhC’s Code of Conduct for Pharmacy Students (2010);
- understand what fitness to practise mechanisms apply to them. All schools of pharmacy must have fitness to practise procedures to deal with student causes for concern undergo required health and good character checks;
- understand that it is an offence to impersonate a pharmacist. Pharmacists are registrants of the GPhC.

Evidence required for meeting this standard

1.2 Evidence sources used to demonstrate meeting this standard include student fitness to practise policies.

1.3 The required evidence should include:

- evidence that the Code of Conduct for Pharmacy Students is used to promote professional conduct;
- summary outcomes of student fitness to practise hearings.
Guidance on meeting this standard

1.4 Anyone who teaches, supervises, counsels, employs or works with students has a responsibility to protect patients and the public. Where serious concerns are raised about a student they must be investigated as soon as possible.

1.5 Students should not be put in a situation where they are asked to work beyond their competence and they must be supervised where necessary.

1.6 Anyone responsible for the education and training of pharmacists has a responsibility to share information relating to health, conduct or performance of students with appropriate people. A student should be asked to agree to this. If they do not or cannot agree, consideration must be given to whether disclosure should take place on patient safety grounds. Patient safety is paramount at all times.

1.7 Students must not be allowed to continue studying if they pose a risk to patients or the public.

1.8 By awarding an accredited OSPAP a university is confirming that a student is fit to enter pre-registration training.

1.9 School fitness to practise policies and procedures must be introduced to students as developmental tools as well as instruments of public protection.

Note

1.10 This standard should be read in conjunction with the GPhC’s Guidance on student fitness to practise procedures in schools of pharmacy, which has further guidance on what constitutes student fitness to practise.

Comment [DD4]: Added in response to consultation feedback about the need for further guidance on student FSP.
Standard 2 – Monitoring, review and evaluation of an OSPAP

Standard

2. The quality of an OSPAP must be monitored, reviewed and evaluated in a systematic and developmental way.

Criteria to meet this standard

2.1 There must be systems and policies in place covering the following:
   - information about roles & responsibilities and lines of accountability;
   - university information on:
     - entry requirements;
     - the quality of teaching, learning and assessment;
     - the quality of placements and other practice learning opportunities;
     - appraisal and feedback systems for students;
     - educational resources and capacity.

   These must be monitored, reviewed and evaluated systematically. When an issue is identified it must be documented and dealt with promptly.

Evidence required for meeting this standard

2.2 Evidence sources for meeting this standard include:

   - integrated evaluations of an OSPAP; By integrated we mean evaluations which look at all aspect of provision;
   - patient and public views on an OSPAP;
   - quality monitoring data from universities relevant to an OSPAP;
   - quality monitoring data from placement providers and other practice learning;
   - sources our accreditation reports and annual school surveys;
   - achievement in the Registration Assessment.

2.3 The required evidence includes:

   - entry requirements and evidence of how they support the aims and philosophy of the programme;
• outcomes of integrated evaluations of an OSPAP;
• views of external stakeholders, including patients and the public, and evidence demonstrating how their views have informed course design and delivery;
• outcomes of evaluations of the quality of teaching, learning and assessment;
• outcomes of evaluations of resources and capacity;
• outcomes of the evaluations of the quality of placements and other practice learning opportunities;
• outcomes of appraisal and feedback systems for students;
• outcomes of achievement in the Registration Assessment.

Note that the evidence above is likely to be included in evaluation processes already in place (and existing processes may well deal with more than one category of evidence).

Guidance on meeting this standard

2.4 Evaluation strategies must evidence 2.3 above.

2.5 Evaluation should include action which is agreed and monitored.

Pre-requisites for meeting this standard

2.6 University quality assurance processes are robust, rigorous and transparent.

2.7 Universities are open with the GPhC about matters affecting an accredited OSPAP. It is a requirement of the Pharmacy Order that course providers assist the GPhC in its work by providing information on request.

2.8 Universities raise relevant issues proactively with the GPhC.
Standard 3 – Equality, diversity and fairness

Standard

3. OSPAPs must be based on principles of equality, diversity and fairness. They must meet the requirements of all relevant legislation.

Information to meet this standard

3.1 Systems and policies for capturing equality and diversity data. Concerns should be documented, addressed and disseminated.

3.2 Strategies for staff training in equality and diversity.

Evidence required for meeting this standard

3.3 Evidence that the OSPAP deals with equality, diversity and fairness issues in an informed way.

3.4 Evidence that concerns have been addressed.

3.5 Evidence that staff and students have been trained in equality and diversity issues and are updated as necessary.

Guidance on meeting this standard

3.6 This standard is intended to ensure that applicants are not treated unfairly on grounds of:

- gender;
- race;
- social;
- background;
- disability;
- religion;
- sexual orientation;
- other forms of discrimination.

The requirements of the Equality Act (2010) should be taken into account in this regard.

3.7 Equality and diversity awareness should be an integral part of an OSPAP.
Standard 4 - Selection of students

Standard

4. Selection processes must be open, fair and comply with relevant legislation. Processes must ensure students are fit to practise as students at the point of selection. Selection includes admissions.

Criteria to meet this standard

4.1 Selection processes must give applicants the guidance they need to make an informed application.

4.2 Selection criteria must be explicit. They should include:
   - meeting the GPhC's adjudication requirements;
   - meeting academic and professional entry requirements;
   - meeting numeracy requirements;
   - recognising prior learning, where that is appropriate.

Health/good character/identity checks and English language requirements will have been addressed as part of the GPhC's adjudication process. Universities may make additional checks.

4.3 Selectors should apply selection criteria fairly. They should be trained to do this. Training should include equality and diversity awareness.

Evidence required for meeting this standard

4.4 Evidence that selection processes and procedures comply with relevant legislation.

4.5 Evidence that the criteria in 4.2 are being applied.

4.6 Evidence that staff involved in selection have been trained appropriately and are aware of relevant legislative requirements.
Guidance on meeting this standard

4.7 All selection requirements should be set out clearly in guidance made available to applicants. Applicants must know what will happen to them during selection, including the GPhC’s role in adjudication.

4.8 Guidance should include information about additional costs associated with making an application.

4.9 It must be made clear to students that the GPhC will carry out its own health, good character and identity checks before registering an applicant. It must be made clear to students that these checks relate to registration and are additional to checks made by universities and employers. It must be made clear to students and trainees that the GPhC may not register a student if a check is failed, even if they have passed previous checks.

4.10 It must be made clear to students that the GPhC will not offer prospective registration advice.

4.11 It must be made clear to students that an applicant can appeal against a registration refusal and that appeals must be made to the GPhC’s Appeals Committee.
Standard 5 – Curriculum delivery and the student experience

Standard

5. The curriculum for OSPAPs must deliver the learning outcomes in standard 10. Most importantly, curricula must ensure students practise safely and effectively. To ensure this, pass criteria must describe safe and effective practice.

Criteria to meet this standard

5.1 Curricula must be integrated. By this the GPhC does not mean that an OSPAP and pre-registration training must be delivered as a single two-year course but that the component parts of an OSPAP must be linked in a coherent way.

5.2 Curricula must be progressive, dealing with issues in increasingly complex ways until the right level of understanding is reached.

5.3 An OSPAP must be delivered in an environment which places study in a professional and academic context and requires students to conduct themselves professionally.

5.4 An OSPAP must be delivered in an environment informed by research. This means that whether or not all staff are engaged in research, their teaching must be informed by current research.

5.5 An OSPAP teaching and learning strategy must set out how students will achieve the learning outcomes in Standard 10. Learning opportunities must be structured to provide:

- an integrated experience of relevant science and pharmacy practice;
- a balance of theory and practice;
- independent learning skills.

5.5 The OSPAP curriculum must include practical experience of working with patients, carers and other healthcare professionals. We are not suggesting that off-site placement visits are the only way to achieve this. Schools should articulate their strategy for meeting this criterion, which may include off-site placement visits, using patients, carers and other healthcare professionals in-class and simulations.
5.6 There must be a clear assessment strategy for the OSPAP. Assessment methods must measure the learning outcomes in standard 10.

5.7 The OSPAP assessment strategy should include:
- diagnostic assessments;
- formative assessments;
- summative assessments;
- timely feedback.

5.8 Academic regulations must be appropriate for a postgraduate qualification that is both academic and professional and leads to further professional training. As a general principle, all assessments, including all components, must be passed. This means that condonation, compensation, trailing, extended resit opportunities and other remedial measures should be extremely limited, if they are permitted at all. Course academic regulations may be more stringent than university norms. This may include higher than usual pass marks for assessments demonstrating knowledge and skills essential to safe and effective pharmacy practice.

5.9 Marking criteria must be used for all assessments and all pass criteria must reflect safe and effective practice.

5.10 Patient safety must be paramount in assessments: any evidence of an assessment demonstrating unsafe practice must result in failure.

5.11 OSPAPs must include an induction programme orientating students to study in the UK. The programme should include diagnostic testing.

Evidence required for meeting this standard

5.12 Evidence sources will include:
- an OSPAP teaching and learning strategy;
- an OSPAP assessment strategy assessment criteria;
- academic regulations;
- OSPAP external examiners' reports;
• reports of OSPAP accreditation visits;
• internal university quality management reports;
• Registration Examination progression data.

5.13 Required evidence will include:

• evidence of the impact of teaching and learning strategies on course delivery and the student experience;
• evidence of the impact of assessment strategies on course delivery and the student experience;
• evidence of the impact of current research on course design;
• evidence that assessment pass criteria reflect safe and effective practice;
• evidence that issues raised during accreditation visits have been addressed;
• evidence that evaluation and feedback from all sources has been acted on;
• evidence that where appropriate reasonable adjustments have been made to course delivery for students;
• evidence that evaluation and feedback from all sources has been acted on;
• Evidence that attrition rates are understood;
• Evidence that Registration Assessment progression data has been used to inform course design.

Note that the evidence above is likely to be included in evaluation processes already in place (and existing processes may well deal with more than one category of evidence).

Guidance on meeting this standard

5.14 There should be a range of teaching and learning methods to deliver the outcomes in Standard 10.

5.15 There should be a range of assessment methods to test all the outcomes in Standard 10.

5.16 Links between diagnostic, formative and summative assessments must be made clear to students.

5.17 Links between assessments and feedback must be made clear. Feedback must be given in time for it to be used effectively.
5.18 There should be deadlines for assessments to be marked and for feedback to be given. Action should be taken if deadlines are not met.

5.19 Where appropriate, reasonable adjustments should be made to curriculum delivery to help disabled students meet learning outcomes. Teaching, learning and assessment can be modified for this purpose but learning outcomes cannot.
Standard 6 – Support and development for students

Standards
6. Students must be supported to develop as learners and professionals during their OSPAP.

Criteria to meet this standard
6.1 There must be a range of mechanisms in place to support students as learners and professionals.

Evidence required for meeting this standard
6.2 Evidence of appropriate personal and professional development, such as student CPD portfolios.

Guidance on meeting this standard
6.3 Students must work with a range of academic and professional role models. The range must include:
   • academic staff in pharmacy, including practice staff, scientists, researchers and support staff;
   • other healthcare professionals.

6.4 Students must have access to support for their academic and general welfare needs. Support must be readily available to students. If students are working off-site appropriate support mechanisms must be in place.

6.5 Students should have access to career advice.

6.6 If it is no longer possible for a student to continue on an OSPAP, they should be told what other options are available to them by their school of pharmacy. There may be a possibility that an interim award such as a postgraduate certificate could be made.
Standard 7 – Support and development for academic staff

Standards

7. Anyone delivering an OSPAP should be supported to develop in their professional roles.

Criteria to meet this standard

7.1 There must be a range of mechanisms in place to support anyone delivering an OSPAP to develop in their professional role.

7.2 Induction programmes are provided for tutors and university staff as appropriate. This should include induction programmes for non-pharmacists working on an OSPAP.

7.3 Everyone involved in delivering the curriculum should have:
   • effective supervision;
   • an appropriate and realistic workload;
   • effective personal support mentoring;
   • time to learn; and
   • continuing professional development opportunities.

Evidence required for meeting this standard

7.4 Evidence that
   • staff appraisal systems address performance issues (anonymised);
   • staff development systems affect course delivery.

Guidance on meeting this standard

7.5 Staff appraisal schemes should take account of the needs of all categories of staff, including practice staff and part-time staff.

7.6 Staff development should be in place for non-pharmacist staff to help them understand how their expertise contributes to an OSPAP and how it can best be delivered in a pharmaceutical context.
Standard 8 – Management of an OSPAP

Standard

8. An OSPAP must be planned and maintained through transparent processes which must show who is responsible for what.

Criteria to meet this standard

8.1 All OSPAPs will be supported by a defined management plan with:

- a schedule of responsibilities;
- defined structures and processes to manage the delivery of an OSPAP.

Evidence required for meeting this standard

8.2 Evidence sources should include:

- management plans. For students this will be course documents;
- evidence of working arrangements between stakeholders, such as clear plans and service level agreements for certain activities;
- university quality monitoring processes and the outcomes of these processes.

8.3 Required evidence includes:

- outcomes of university quality management process affecting OSPAPs;
- service level agreements or other agreements between stakeholders;
- evaluations of the relationship between stakeholders and actions taken to address issues.

Guidance on meeting this standard

8.4 Systems and structures should be in place to manage the learning of students in the academic environment. They must take account of:

- access to and availability of suitable learning facilities;
- the balance between taught components, directed learning and student / trainee self-
study;
- student attendance, particularly minimum requirements and what is compulsory;
- mechanisms to ensure structured, off-site learning is quality assured and linked to specified areas of the curriculum and learning outcomes. This must include the quality assurance of placements and placement staff.

8.5 Systems and structures should be in place to manage the learning of students in practice. They must take account of

- access to and availability of suitable learning facilities;
- managing and monitoring attendance;
- ways in which students can communicate with tutors and staff when they are off-site.
Standard 9 – Resources and capacity

Standard

9. Resources and capacity are sufficient to deliver learning outcomes.

Criteria to meet this standard

9.1 There must be:

- robust and transparent mechanisms for securing an appropriate level of resource for delivering an OSPAP;
- sufficient staff from relevant disciplines to deliver the curriculum to students. Staff must be appropriately qualified and experienced. The staffing profile must include:
  - sufficient numbers of pharmacists – registrants of the GPhC - with experience of teaching in higher education to ensure that an OSPAP can produce students equipped to enter pharmacist pre-registration training in Great Britain;
  - sufficient numbers of pharmacists to act as tutors and professional mentors at university. Not all personal tutors must be pharmacists;
  - pharmacists who are leaders in the profession, the school and in their university, who can influence school and university policy relevant to pharmacy;
  - non-pharmacist academics who can influence school and university policy relevant to pharmacy;
  - science academics who understand the relevance of their discipline to pharmacy and deliver their area of expertise in a pharmaceutical context;
  - academic pharmacists and other experienced pharmacy staff who are able to act as mentors to non-pharmacist colleagues;
- career pathways in universities for all staff teaching on OSPAPs, including pathways for practice staff;
- clear lines of authority and responsibility for the strategic organisation and day-to-day management of placements;
- recognised training and ongoing support for all non-pharmacists involved in the delivery of OSPAPs which must:
  - help them understand the relevant of their work to pharmacy; and
  - how to deliver their area of expertise in a pharmaceutical context;
• appropriate learning resources;
• accommodation and facilities that are fit for purpose.

Evidence required for meeting this standard

9.2 Required evidence will include:

• evidence that there are mechanisms for securing appropriate levels of resource sufficient to deliver an OSPAP to the required standard;
• evidence that the staffing profile can support the delivery of the course and the student experience;
• evidence that the staffing profile includes pharmacists who are leaders in the profession, the school and in their university, who can influence school and university policy relevant to pharmacy;
• evidence that the staffing profile includes non-pharmacists who can influence schools and university policy relevant to pharmacy;
• career structures for all categories of staff, including practice staff;
• evidence that the staffing profile includes a critical mass of pharmacists sufficient to ensure the course is focused on the profession of pharmacy;
• evidence that there is recognised training and ongoing support for all non-pharmacist staff to ensure their contribution to an accredited course is orientated to pharmacy;
• evidence that learning resources are fit for purpose;
• evidence that accommodation and facilities are fit for purpose.

Guidance on meeting this standard

9.3 OSPAP providers exercise an appropriate level of autonomy over pharmacy resources to deliver an OSPAP to the required standard and in an appropriate learning environment. The precise nature of the autonomy of pharmacy and its senior managers will be determined by the institutional context in which pharmacy finds itself. However, whatever the context, there must be robust and transparent ways of securing resources for pharmacy.

9.4 OSPAP learning environments must support students achieve the outcomes in Standard 10.

9.5 These standards describe the types of staff required to deliver an OSPAP. Some OSPAP staff must
be pharmacists. It is important to remember what the legal definition of a pharmacist is:

'A person practices as a pharmacist or pharmacy technician if, whilst acting in the capacity of or purporting to be a pharmacist or pharmacy technician, that person undertakes any work or gives any advice in relation to the preparation, dispensing, sale, supply or use of medicines, the science of medicines, the practice of pharmacy or the provision of healthcare.' (Pharmacy Order 2010)

In a university context, this definition is not restricted to staff who teach pharmacy practice but includes staff involved in 'the provision of healthcare' and 'the science of medicines' among other things. This definition means that staff other than teacher-practitioners or pharmacy practice staff may be registered as pharmacists.

Note: The GPhC does not have a non-practising registration category.
Standard 10 – Learning outcomes

Context

To be safe and effective, the practice of pharmacy must be underpinned by relevant and up-to-date science. Sound science is the basis of effective pharmacy.

Students must be able to

- study safely and effectively;
- study ethically and lawfully;
- understand and apply biomedical and pharmaceutical science principles, method and knowledge;
- understand and apply psychological and social science principles, method and knowledge; and
- understand and apply population and improvement science principles, method and knowledge.

The outcomes defined in this section are practical and describe safe and effective pharmacy practice. The practice of pharmacy requires pharmacists to make decisions in complex and unpredictable situations, sometimes in the absence of complete data. Pharmacists need to communicate with patients and the public clearly; often they will need to explain complicated ideas in a way that is understandable to patients and carers. Equally, pharmacists need to understand the complexities of patients' circumstances insofar as they are relevant to their medicines use or other behaviours relevant to personal health & wellbeing.

As professionals, pharmacists must act on their own initiative and take personal responsibility for what they do. Pharmacists need to have the independent learning ability required for
continuing professional development in order to maintain a critical awareness of current practice. To prepare students for this, an OSPAP is at master’s level (as defined by the UK’s Quality Assurance Agency).

OSPAP students will have trained and worked as pharmacists outside the EEA. This means that they should be at least competent as a professional in their country of establishment.

The purpose of an OSPAP and pre-registration training in Great Britain is to ensure that non-EEA pharmacists are at least competent practitioners in Great Britain too.

Describing and assessing learning outcomes

The outcome levels in standard 10 have been derived from a competence and assessment hierarchy, known as Miller’s triangle (Miller GE. The assessment of clinical skills / competence / performance. Acad Med 1990; 65:563-7). Although Miller developed the triangle for clinical work, it can be applied to science too.

![Miller's triangle diagram]

As what is being assessed at each of the four levels is different, the assessment types associated with the levels are different too, although there will be some overlap.

**Level 1 – Knows.** Knowledge that may be applied in the future to demonstrate competence. Assessments may include essays, oral examinations and MCQs.
Level 2 - Knows how. Context-based tests - knows how to use knowledge and skills. Assessments may include essays, oral examinations, MCQs, and laboratory books.

Level 3 - Shows how. A student or trainee is able to demonstrate that they can perform in a simulated environment or in real life. Assessments may include Objective Structured Clinical Examinations (OSCEs), simulated patient assessments, designing, conducting and reporting an experiment, dispensing tests and taking a patient history.

Level 4 – Does. Acting independently and consistently in the complex situation of an everyday or familiar context. Evidence for this level is showing in this context that one is able to demonstrate the learning outcomes in a complex everyday situation repeatedly and reliably. Assessments may include OSCEs and taking a patient history.

Note that these levels do not equate directly to years of study.

Teaching and learning

A curriculum should not be formulaic and should include a variety of teaching and learning methods. Typically, teaching and learning methods should result in

- learning based on experience that provides clinical education in a range of practices and procedures
- learning based on experience that provides scientific education in a range of practices and procedures
- learning based on experience that provides education in inter-professional practices and procedures with other healthcare professionals
- learning that enables the demonstration of behaviours, attitudes and values set out in the GPhC's code of conduct for pharmacy students
- learning that integrates theory and practice opportunities for developing the skills students/trainees need to become self-directed learners
- opportunities to reflect on learning and practice and to discuss issues with staff and peers. This should include activities like pharmacist continuing professional development
(CPD) and
- opportunities for students to develop specialist knowledge, for example veterinary/industrial pharmacy or recent advances in science relevant to pharmacy.

As an OSPAP is a master's level course, all the assessments must be at either QAA Level 6 or 7, with at least 75% (the equivalent of 90 credits) at level 7.

The link between teaching, learning and assessment

The link between teaching and learning and assessment must be explicit. Assessment must complement teaching and learning. Assessment must test competence and the achievement of learning outcomes in this standard. Ensuring this will be a central feature of our quality assurance processes.

Devolution

The GPhC's register is GB-wide. By country of residence the split is 80%+ in England, 10% in Scotland, 5% in Wales, with the remainder overseas. As students may work in any country, they must be made aware of the similarities and differences in the provision of healthcare in the countries of Great Britain.
Learning outcomes for non-EEA pharmacists wanting to register in Great Britain

10.1 Expectations of a pharmacy professional

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>OSPAP</th>
<th>Pre-reg (for reference)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognise ethical dilemmas &amp; respond in accordance with relevant codes of conduct</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>2. Recognise the duty to take action if a colleague’s health, performance or conduct is putting patients or public at risk</td>
<td>Knows how</td>
<td>Knows how</td>
</tr>
<tr>
<td>3. Recognise personal health needs, consult and follow the advice of a suitability qualified professional, and protect patients or public from and risk posed by personal health</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>4. Apply the principles of clinical governance in practice</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>5. Demonstrate how the science of pharmacy is applied in the design and development of medicines and devices</td>
<td>Shows how</td>
<td>Knows how</td>
</tr>
<tr>
<td>6. Contribute to the education and training of other members of the team, including peer review and assessment</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>7. Contribute to the development of other members of the team through coaching and feedback</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>8. Engage in multidisciplinary team working</td>
<td>Knows how</td>
<td>Does</td>
</tr>
</tbody>
</table>

10.2 The skills required in practice

Implementing health policy

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>OSPAP</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Promote healthy lifestyles by facilitating access to and understanding of health promotion information</td>
<td>Shoes how</td>
<td>Does</td>
</tr>
</tbody>
</table>
2. Access and critically evaluate evidence to support safe, rational & cost effective use of medicines

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>OSPAP</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify and employ the appropriate diagnostic or physiological testing techniques in order to promote health</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>2. Identify inappropriate health behaviours and recommend suitable approaches to interventions</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>3. Instruct patients in the safe and effective use of their medicines and devices</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>4. Analyse prescriptions for validity and clarity</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>5. Clinically evaluate the appropriateness of prescribed medicines</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>6. Provide, monitor and modify prescribed treatment to maximise health outcomes</td>
<td>Shows how</td>
<td>Does</td>
</tr>
</tbody>
</table>

Validates therapeutic approaches and supplies prescribed and over the counter medicines.
7. Communicate with patients about their prescribed treatment | Shows how | Does
8. Optimise treatment for individual patient needs in collaboration with the prescriber | Shows how | Does
9. Record, maintain and store patient data | Shows how | Does
10. Supply medicines safely and efficiently, consistently within legal requirements and best professional practice. NB This should be demonstrated in relation to both human and veterinary medicines. | Shows how | Does

Ensure safe and effective systems are in place to manage risk inherent in the practice of pharmacy and the delivery of pharmaceutical services

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>OSPAP</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ensure quality of ingredients to produce medicines and products</td>
<td>-</td>
<td>Shows how</td>
</tr>
<tr>
<td>2. Apply pharmaceutical principles to the formulation, preparation and packaging of products</td>
<td>Shows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>3. Use pharmaceutical calculations to verify the safety of doses and administration rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Develop quality management systems including maintaining appropriate records</td>
<td>Shows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>5. Manage and maintain quality management systems including maintaining appropriate records</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>6. Procure and store medicines and other pharmaceutical products working within a quality assurance framework</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>7. Distribute medicines safely, legally and effectively</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>8. Dispose of medicines safely, legally and effectively</td>
<td>Knows how</td>
<td>Does</td>
</tr>
</tbody>
</table>

Comment [DD13]: Reworded for clarity – MPC suggested wording
9. Manage resources in order to ensure work flow and minimise risk in the workplace | Knows how | Shows how

10. Take personal responsibility for health and safety | Knows how | Does

11. Work effectively within teams to ensure safe and effective systems are being followed | Knows how | Does

12. Ensure the application of appropriate infection control measures | Shows how | Does

13. Supervise others involved in service delivery | Knows how | Does

14. Identify, report and prevent errors and unsafe practice | Shows how | Does

15. Procure, store and dispense and supply veterinary medicines safely and legally | Knows how | Knows how

- Working with patients and the public

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>OSPAP</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish and maintain patient relationships while identifying patients’ desired health outcomes and priorities</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>2. Obtain and record relevant patient medical, social and family history</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>3. Identify and employ the appropriate diagnostic or physiological testing techniques to inform clinical decision making</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>4. Communicate information about available options in a way which promotes understanding</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>5. Support the patient in choosing an option by listening and responding to their concerns and respecting their decisions</td>
<td>Shows how</td>
<td>Does</td>
</tr>
<tr>
<td>6. Conclude consultation to ensure a satisfactory outcome</td>
<td>Shows how</td>
<td>Does</td>
</tr>
</tbody>
</table>

30
7. Maintain accurate and comprehensive consultation records | Shows how | Does
---|---|---
8. Provide accurate written or oral information appropriate to the needs of patients, the public or other healthcare professionals | Shows how | Does

Maintain and improve professional performance

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>OSPAP</th>
<th>Pre-reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate the characteristics of a prospective professional pharmacist as set out in relevant codes of conduct and behaviour</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>2. Reflect on personal and professional approaches to practice</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>3. Create and implement a personal development plan</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>4. Review and reflect on evidence to monitor performance and revise professional development plan</td>
<td>Does</td>
<td>Does</td>
</tr>
<tr>
<td>5. Participate in audit and in implementing recommendations</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
<tr>
<td>6. Contribute to identifying learning and development needs of team members</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>7. Contribute to the development and support of individuals and teams</td>
<td>Knows how</td>
<td>Does</td>
</tr>
<tr>
<td>8. Anticipate and lead change</td>
<td>Knows how</td>
<td>Shows how</td>
</tr>
</tbody>
</table>
Appendix 1 – Indicative syllabus

A1.1 How medicines work

**Therapeutics**
- Routes of administration
- New therapeutic advances
- Infection control
- Complementary therapies
- Clinical therapeutic uses of drugs

**Applied Physical, Chemical and Biological sciences**
- (Bio) Analytical principles and methods
  - Pharmaceutical analytical instrumentation
  - Scope and limitations of analytical techniques
  - Advanced instrumental methods
  - Drug identification
- Drug design and discovery
  - Drug targets
  - Structure: activity relationships
  - Molecular modelling
- Cell and molecular biology
  - Prokaryotic and eukaryotic cell structure and function
  - Major cell components
  - Cell signalling
  - Membrane transport
  - Cell biochemistry: biosynthetics and metabolism
  - Cellular genetics
- Microbiology
  - Classification and identification
  - Bacteria, fungi, viruses, protozoa, helminths
  - Replication
  - Pathogenicity and virulence
- Immunology
  - transplantation
  - vaccination
  - diagnostics

- Pharmaceutical chemistry
  - chemical structure, bonding and nomenclature
  - chemical functional groups and reactivity
  - drug synthesis
  - thermodynamics and chemical kinetics
  - physicochemical properties of drug molecules
  - sources and purification of medicinal substances, including natural products

Pharmacology, pharmacokinetics & pharmacodynamics
- Contraindications, adverse reactions and drug interactions
- Absorption, distribution, metabolism and excretion (ADME)
- Pharmacokinetic modeling
- Bioavailability and bioequivalence
- Prediction of drug properties
- Pharmacogenetics and pharmacogenomics
- Drug and substance misuse
- Clinical toxicology and drug-over-exposure
- Molecular basis of drug action
- Metabolism

Pharmaceutical technology including manufacturing & engineering science
- Biotechnology
  - biotechnological use of microorganisms
  - recombinant DNA technology
  - transgenic animals
  - tissue engineering
• Manufacturing methods
• Quality assurance processes, including raw materials and products
• Sterilisation and asepsis
• Environmental control in manufacturing

Formulation and material science
• Materials used in formulations and devices
• Dosage forms
• Formulation principles
• Biopharmaceutics, developmental pharmaceutics, pre-formulation and formulation studies
• Design and standardisation of medicines
• Microbiological contamination
• Contamination control
• Product stability
• Medical devices

A1.2 How people work

Normal & abnormal structure & function
• Nutrition
• Anatomy and physiology
  o physiological regulation and homeostasis
  o neural communication and control
  o clinical immunology: autoimmune disease; hypersensitivity reactions
• Pathology
• Infectious diseases and infective processes
• Wound repair
Sociology
- Social and behavioural science
- Drug misuse
- Drugs in sport

Health psychology
- Health promotion
- Disease prevention
- Behavioural medicine

Objective diagnosis
- Differential diagnosis
- Symptom recognition
- Diagnostic tests

Epidemiology
- Aetiology and epidemiology of (major) diseases

A1.3 How systems work

Healthcare management
- Public health
- Organisations: National Health Service (NHS), Department of Health (DH), governmental priorities
- Other professionals
- Health care systems
- Veterinary pharmacy

Evidence-based practice
- Health information systems/ resources
- Health policy and (pharmaco)economics
• Health-related quality of life
• Pharmacovigilance

Professional regulation
• Legislation
• Professional ethics and fitness to practise
• Sale and supply of medicines
• CPD
• Political and legal framework

Medicines regulation
• Evaluation and regulation of new drugs and medicines
• Pharmacopoeial specifications and biological standards
• Medicines licensing
• Product quality, safety and efficacy
• The supply chain
• Packaging, labelling and patient information

Clinical governance
• Standard Operating Procedures (SOPs)
• Research methodology / research ethics
• Risk & quality management
• Good manufacturing/dispensing practice
• Good clinical practice
• Health policy, clinical and science research methods

Clinical management
• Disease management
• Chronic medicines management
• Medicines use review
• Care planning
• Therapeutic drug monitoring
Workplace Regulation

- Health & Safety
- Sexual boundaries
- Independent Safeguarding Authority
- Data protection
- Freedom of Information Act (FOIA)
- Consumer protection, including complaints procedures

A1.4 Core and transferable skills

Professionalism

Research (including research methods)

Critical appraisal

- Audit and learning from errors
- Analysis of evidence
- Evaluation of the literature

Problem solving

- Study skills
- Team-working skills
- Integrating knowledge from multiple sources

Clinical decision making

- Leadership skills

Accurate record keeping

Reflective practice [including continuing professional development]

Effective communication

- Interpersonal skills
- Medical terminology

Interpret & interrogate clinical/scientific data

Analyze & use numerical data
Pharmaceutical numeracy

Literature searching

A1.5 Attitudes and values

See the Code of conduct for pharmacy students (2010) and Standards of conduct, ethics and performance (2010)
Appendix 2 - European requirements for the initial education and training of pharmacists

The European Community’s Directive 2005/36/EC on the European Parliament and of the Council on the recognition of professional qualifications includes requirements for the initial education and training of pharmacists. The requirements constitute the Minimum Training Requirement (MTR). They include

Section 7 Pharmacist

Article 44 Training as a pharmacist

2. Evidence of formal qualifications as a pharmacist shall attest to training of at least five years’ duration, including at least:
   (a) four years of full-time theoretical and practical training at a university or at a higher institute of a level recognised as equivalent or under the supervision of a university;
   (b) six-month traineeship in a pharmacy which is open to the public or in a hospital, under the supervision of that hospital’s pharmaceutical department.

3. Training for pharmacists shall provide an assurance that the person concerned has acquired the following knowledge and skills:
   (a) adequate knowledge of medicines and the substances used in the manufacture of medicines;
   (b) adequate knowledge of pharmaceutical technology and the physical, chemical, biological and microbiological testing of medicinal products;
   (c) adequate knowledge of the metabolism and the effects of medicinal products and of the action of toxic substances, and of the use of medicinal products;
   (d) adequate knowledge to evaluate scientific data concerning medicines in order to be able to supply appropriate information on the basis of this knowledge;
   (e) adequate knowledge of the legal and other requirements associated with the pursuit of pharmacy.
Article 45 Pursuit of the professional activities of a pharmacist

2. The Member States shall ensure that the holders of evidence of formal qualifications in pharmacy at university level or a level deemed to be equivalent, which satisfies the provisions of Article 44, are able to gain access to and pursue at least the following activities, subject to the requirement, where appropriate, of supplementary professional experience:

(a) preparation of the pharmaceutical form of medicinal products;
(b) manufacture and testing of medicinal products;
(c) testing of medicinal products in a laboratory for the testing of medicinal products;
(d) storage, preservation and distribution of medicinal products at the wholesale stage;
(e) preparation, testing, storage and supply of medicinal products in pharmacies open to the public;
(f) preparation, testing, storage and dispensing of medicinal products in hospitals;
(g) provision of information and advice on medicinal products.¹

The syllabus is at V.6. Pharmacist 5.6.1. Course of training for pharmacists.
Appendix 3 - OSPAPs and national & European requirements for master’s level qualifications

The United Kingdom is a signatory to the Bologna Declaration. The Declaration produced a number of common Actions which have been designed to harmonize higher education qualifications across Europe. Because it is a signatory, the United Kingdom has agreed to operate a degree system including bachelor, masters and doctoral qualifications. Maximum and minimum credit limits and durations have been set for each type of qualification. OSPAPs are postgraduate diplomas.

All accredited OSPAPs must have a minimum of 120 UK credits, of which at least 90 credits must be at master’s level. OSPAPs must be one academic year long full time or part time equivalent. OSPAPs with these characteristics are compliant with the requirements of

- the Framework for Qualifications in the European Higher Education Area
- the UK Quality Assurance Agency’s Framework for Higher Education Qualifications (covering England, Wales and Northern Ireland) and
- the Scottish Credit and Qualifications Framework Partnership’s Scottish Credit and Qualifications Framework.

QAA Framework for Higher Education Qualifications - Descriptor for a higher education qualification at level 7 (Master’s degrees)

The descriptor provided for this level of the framework is for any master’s degree which should meet the descriptor in full. This qualification descriptor can also be used as a reference point for other level 7 qualifications, including postgraduate certificates and postgraduate diplomas.

Master’s degrees are awarded to students who have demonstrated

- a systematic understanding of knowledge, and a critical awareness of current problems and/or new insights, much of which is at, or informed by, the forefront of their academic discipline, field of study or area of professional practice
- a comprehensive understanding of techniques applicable to their own research or advanced scholarship
- originality in the application of knowledge, together with a practical understanding of how established techniques of research and enquiry are used to create and interpret knowledge
In the discipline

- conceptual understanding that enables the student
  - to evaluate critically current research and advanced scholarship in the discipline
  - to evaluate methodologies and develop critiques of them and, where appropriate,
    to propose new hypotheses.

Typically, holders of the qualification will be able to

- deal with complex issues both systematically and creatively, make sound judgements in the absence of complete data, and communicate their conclusions clearly to specialist and non-specialist audiences
- demonstrate self-direction and originality in tackling and solving problems, and act autonomously in planning and implementing tasks at a professional or equivalent level
- continue to advance their knowledge and understanding, and to develop new skills to a high level.

And holders will have

- the qualities and transferable skills necessary for employment requiring
  - the exercise of initiative and personal responsibility
  - decision-making in complex and unpredictable situations
  - the independent learning ability required for continuing professional development.
Appendix 4 - Sites for pharmacist pre-registration training

Pre-registration training may take place on any site approved by the GPhC. This includes:

- community pharmacies;
- NHS hospital pharmacies;
- primary care trusts;
- schools of pharmacy with an accredited MPharm degree;
- the pharmaceutical industry;
- prison pharmacies;
- mental health trusts;
- private hospitals;
- registered pharmacies engaged solely in the supply of animal and agricultural products.

At least 26 weeks of the 52 weeks of pre-registration training must be patient-facing.
Other standards and guidance

There are separate standards for the initial education of pharmacists studying in Great Britain: Future pharmacists: standards for the initial education and training of pharmacists

Once registered, pharmacy professionals must meet our Standards of conduct, ethics and performance and Standards of continuing professional development

You can find these documents at www.pharmacyregulation.org

Reference documents

Accreditation and Recognition Manual (GPhC, 2011; in preparation)

Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals (Council for Healthcare Regulatory Excellence (CHRE))

Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practice panels (CHRE)

Code of Conduct for Pharmacy Students (General Pharmaceutical Council (GPhC), 2010)

Code of Practice for the assurance of academic quality and standards in higher education (Quality Assurance Agency (QAA))

Dimensions of quality (Gibbs, G., Higher Education Academy, 2010, www.hea.ac.uk)


Fitness to Practise in Schools of Pharmacy: a Literature Review (Schafheutle et al on behalf of the RPSGB, 2009)

Framework for higher education qualifications in England, Wales and Northern Ireland (QAA, 2008)

Framework for Qualifications in the European Higher Education Area
(http://www.ond.vlaanderen.be/hogeronderwijs/Bologna/qf/overarching.asp)

From pharmacy education into pre-registration training (Willis, S. et al., Centre for Workforce Studies @ The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2007)

Good character assessment framework template (contact GPhC)

Guidance on Student Fitness to Practise Procedures in Schools of Pharmacy (GPhC, 2010)

Health assessment framework template (contact GPhC)
Healthcare Professional Education & Training: How does Pharmacy in Great Britain compare? (Wright, D. et al, University of East Anglia for the RPSGB, 2006)

Higher education credit framework for England: guidance on academic credit arrangements in higher education in England (QAA, 2008)

IELTS Guide for Stakeholders (International English Language Testing System (IELTS), 2009)

Institutional audit of higher education institutions in England and Northern Ireland, operational description (draft; QAA, 2010)

Learning about sexual boundaries between healthcare professionals and patients: a report on education and training (CHRE)

Learning from innovation in pharmacy education (PPRT, 2007)


MPharm Programmes: Where are we now? (Wilson, K et al, Aston University Pharmacy Practice Research Group, Pharmacy Practice Research Trust (PPRT), 2005)

MPharm Student Code of Conduct: a Literature Review (Schafheutle et al on behalf of the RPSGB, 2009)


The Pharmacy Order (Department of Health, 2010)

Pharmacy Undergraduate Students: Career Choices and Expectations across a Four-Year Programme (Wilson, K. et al, the Aston University Pharmacy Practice Research Group, PPRT, 2006)

Pre-registration Performance Standards (in GPhC Pre-registration Trainee Workbook)

Pre-registration Trainee Workbook (GPhC, annual)

Pre-registration Tutor Workbook (GPhC, annual)

Registration Examination Syllabus (in Pre-registration Trainee Workbook)

Revised Performance Review Process and Standards (CHRE, 2010)

Scottish Credit and Qualifications Framework (Scottish Credit and Qualifications Framework Partnership, http://www.scqf.org.uk/home/home.aspx)

Sexual boundary violations by health professionals – an overview of the published empirical literature (CHRE)
Standards of conduct, ethics and performance (GPhC, 2010)

Standards of conduct, ethics and performance for pre-registration trainee pharmacists (GPhC, 2011)

Studying Pharmacy: who, when, how why? What next? (Willis, S. et al., Centre for Workforce Studies @ The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2006)

Work, employment and the early careers of cohort pharmacists (Willis, S. et al., Centre for Workforce Studies @ The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2009)

Working lives of pre-registration trainees (Willis, S. et al., Centre for Workforce Studies @ The Workforce Academy, School of Pharmacy, University of Manchester, PPRT, 2008)

Websites

General Pharmaceutical Council (GPhC): http://www.pharmacyregulation.org/
British Pharmaceutical Students’ Association (BPSA): http://www.bpsa.co.uk/
Council of University Heads of Pharmacy (CUHOP): http://www.cuhop.ac.uk/
International English Language Testing Service (IELTS): http://www.ielts.org
National Recognition Information Centre for the United Kingdom (NARIC): http://www.naric.org.uk/
Pharmaceutical Society of Northern Ireland (PSNI): http://www.psni.org.uk/
Royal Pharmaceutical Society (RPS): http://www.rpharms.org/
Quality Assurance Agency (QAA): http://www.qaa.ac.uk/
UK Border Agency (UKBA): http://www.ukba.homeoffice.gov.uk/
Standards for the education and training of pharmacists: an analysis

1.0 Analysis of consultation responses

Responding Organisations

i. General

Academic of Pharmaceutical Sciences
APPLET: Advancing the Provision of Pharmacy Law and Ethics
BPSA: British Pharmaceutical Students Association
British Society for the History of Pharmacy
CHRE: Council for Healthcare Regulatory Excellence
CPPE: Centre for Pharmacy Post-Graduate Education
CPS: College of Pharmaceutical Sciences
CQC: Care Quality Commission
CUHOP: Council of University Heads of Pharmacy
FIP: International Pharmacy Federation
Guild of Healthcare Pharmacists
Health Departments in England, Scotland and Wales
IPMI: Institute of Pharmacy Management
Pharmacy Councils of Australia and New Zealand (joint response)
PSNI: Pharmaceutical Society of Northern Ireland
RPS: Royal Pharmaceutical Society
RPS Industrial Pharmacists Group

ii. Community Pharmacists/ies and Trade Associations*

Boots
CCA: Company Chemists Association
Co-Op
Lloyds Pharmacy
NPA: National Pharmacy Association
Novartis
Welldricks

iii. Groups

Community Health Councils
LINKs: Local Involvement Networks (and other patients groups)
Local community development groups
NHS training organisations*
Schools of Pharmacy(all)
YMCA

iv. Patient/User Groups

User/support groups (20):-
for disabled people,
older people/pensioners
carers, and
patients
MENCAP
Parkinsons UK
Royal National Institute for the Deaf

v. Individuals

Chief Pharmaceutical Officers
Academic pharmacists
Community pharmacists
GPhC agents (e.g. accreditors) responding with private views
Hospital pharmacists
Industry pharmacists
Patients
Service users
Trainers and educators

*NB responding as placement providers

vi. Number of narrative responses (including contributions to discussions)

Organisations 20
Groups 106
Individuals 50

Organization means a national representative body; group means a local or regional organisation (such as a school of pharmacy, NHS training organisation or private training provider); and individual means a pharmacist, student, someone replying in their own behalf (and not from the organisation with which they are associated) or member of the public.

A total of around 370 organisations, groups and individuals engaged directly with the seminar and survey processes. This makes it one of the largest consultations ever undertaken by a pharmacy regulator. All SoPs responded, and in some Schools the majority of staff attended the relevant seminar, for example. Hundreds of non-pharmacy organisations and individuals engaged with the Patient and Public Involvement seminars, and the representative groups (e.g. LINKs or patients' organisations) carry with them the voices of thousands of their members.
Methodology

To analyse the data, narrative responses were tabulated by question then common themes were identified. To get a better sense of whether views were individual or more widely representative, responses were categorised as either organization, group or individual.

For each of the principal questions, a statistical summary is presented along with a brief commentary, summarising the narrative responses. Comments from organizations, groups and individuals have been presented separately, for Council members to gain a better sense of the significance of a view.

Responses were received in two very different formats. The majority of those who engaged with the consultation did so via seminars (275) while 95 contributed via an online survey and with individual narrative responses. To analyse the responses these 370 or so contributions have been amalgamated. Each comment recorded from the seminars has been notionally attributed to one respondent in order to allow numerical manipulation and analysis of the data. This approach is justified because of the consistency of the responses and because it balances out across the whole exercise. Many of the on-line respondents answered “no” to some of the questions, but this was more an artefact of the survey methodology to allow them to continue and submit either reservations about the proposals or constructive comments for improving or extending them. In the analysis most “nos” are categorised as expressing reservations (and, therefore, “unsure”) about the proposals rather than rejecting them in principle, which would give a false picture of the way the proposals were received. Most of the reservations were concerns about their implementation rather than feeling that the idea was fundamentally misguided. These reservations are captured in the commentary. The result was an overwhelming endorsement of the proposals with a body of valuable comment, and this was very much borne out by the experience of the discussions at the seminars.

The base number of 370 for comments changes with the different questions because there were five special interest responses that only made comment and did not address any of the questions, and it was clear that the PPI respondents did not feel they had the expertise to address all the individual standards or the questions (e.g. relating to the OSPAPs). This avoids the anomaly of people who chose not to respond for considered reasons being recorded as “no” or “unsure” or “skipped question”, when none of these were their intention.

Percentages have been expressed as whole numbers for clarity.

For each of the principal questions, a statistical summary is presented along with a brief commentary, summarising the narrative responses. Comments from organizations, groups and individuals have been presented separately, for Council members to gain a better sense of the significance of a view.

The responses were collected in three very different formats. The majority of those who engaged with the consultation did so via seminars. These were held across the UK (and not just GB), were very well attended, were much appreciated and drew in all sectors and interests. The next largest input was via an online survey. About 25 responses were by individual separate submission.

The data collected on the respondents was different in all three cases, which means that only a global account can be given of the spread of responses by sector and
country. (Neither the seminar attendees nor the individual submissions, for example, were asked to specify postal address or sector, although most provided enough information to allow country and whether they were pharmacists or not to be identified). It is immediately clear, however, that an unusually wide range of interests with an appropriate geographical spread did respond. One artefact of the seminar format was that questions could be explained and it attracted, therefore, a much lower level of requests for clarification as consultation responses.
The responses

1.1 Personal details

Some 370 responses can be identified from all three GB countries and from overseas (including Northern Ireland). The majority are from pharmacists in the academic, community pharmacy and NHS sectors and with a third being from the PPI seminars. Not all respondents provided full personal details or capacities, but sectors and countries can be identified and these are set out in the analyses below.

1.2 Please indicate all the countries from which your comments originate or to which they relate

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Britain</td>
<td>3.0%</td>
<td>11</td>
</tr>
<tr>
<td>England</td>
<td>55.0%</td>
<td>204</td>
</tr>
<tr>
<td>Scotland</td>
<td>18.0%</td>
<td>66</td>
</tr>
<tr>
<td>Wales</td>
<td>17.0%</td>
<td>62</td>
</tr>
<tr>
<td>Overseas</td>
<td>10.0%</td>
<td>38</td>
</tr>
</tbody>
</table>

answered question 370
skipped question 0
1.3 *Are you responding on behalf of an organisation or group?*

*Comment*

Groups include:-  
National pharmacy and non-pharmacy organisations,  
Professional and regulatory bodies,  
NHS pharmacy (and GB Health Departments),  
Community pharmacy,  
Local non-pharmacy groups, and  
All the Schools of Pharmacy and umbrella academic pharmacy bodies.
2.4 Area of Work

![Bar chart showing area of work with percentages and counts for different fields]

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community pharmacy</td>
<td>2.0%</td>
<td>7</td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>14.0%</td>
<td>53</td>
</tr>
<tr>
<td>Professional/regulatory</td>
<td>2.0%</td>
<td>7</td>
</tr>
<tr>
<td>Pharmacy education and training</td>
<td>41.0%</td>
<td>152</td>
</tr>
<tr>
<td>Pharmaceutical industry</td>
<td>1.0%</td>
<td>2</td>
</tr>
<tr>
<td>Other (please give details)</td>
<td>42.0%</td>
<td>156</td>
</tr>
</tbody>
</table>

**Comments**

Most of the "others" are accounted for by the PPI respondents showing that a much wider constituency than just pharmaceutical interests and expertise was reached. The first five categories are almost all composed of pharmacists with an interest in initial education and training, bringing that sector up to over 50% of respondents when composited. The analysis shows, though, that the academic pharmacists and their umbrella bodies were not the only significant voices in the consultation with expert views on initial education and training. The seven community pharmacist responses reflect the number of companies or organisations engaging, and there were probably more individuals than that number involved overall.
1.4 Question 1. [Future pharmacists]: Overall, are the 10 standards fit for purpose?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>88.0%</td>
<td>324</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>7.0%</td>
<td>26</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td>67</td>
</tr>
</tbody>
</table>

Question 1: Future pharmacists - Overall, are the 10 standards fit for purpose?

Comments

Substantial majority in favour. CUHOP’s comment is that the standards are ‘fair and reasonable’.

The overall package was accepted as a basis for discussion and development, so very few responses could be seen as rejecting the proposals out of hand or expressing such reservations as to make them unworkable. Most ostensibly adverse comments were about the need to clarify, refocus or add to the proposals or to revisit the basis on which they were proposed and can be treated as constructive comment. They largely account for the “unsure” numbers, almost all generated from the survey responses from the academic sector, and there is a note on them below.

The perception that there was not enough emphasis on science (and that the pharmacist is as much a scientist as a clinician) was the single most frequent comment and from all the non-PPI sectors. (Against this, one SoP commented that it had every confidence that it would always have the capacity to build enough science into the curriculum using GPhC guidance as its point of departure).
Another theme was a lack of business skills and/or management training. However, some respondents wanted basic bookkeeping/financial management skills while others wanted much more advanced professional management training and training in clinical leadership. This consultation has highlighted that some areas could be developed further and this is one of them.

The positive comments (other than just straight-forward endorsements) were at a more abstract level and included:

- the move from inputs to outputs especially welcome,
- the standards would facilitate the option of developing of an integrated 5 year degree,
- the greater flexibility is welcome, and
- greater patient focus is a benefit.

One PPI input said that there should be a requirement in the standards for pharmacists to be able to educate their patients. More generally the PPI input suggested that pharmacists were not receiving enough preparation in "people skills" and that this needed to be more explicit in the standards. (There is a caveat here, the PPI attendees were commenting about the generality of pharmacists currently in practice and not separating out issues affecting long-established practitioners from those newly admitted to the register. This means that many of the issues of concern to them may be historical in terms of actions taken over recent years by the pharmacy educators and regulators).

There were no conflicts between the submissions made by different sectors or between organisations, groups and individuals, although a few mutually exclusive comments were made against the detail of some individual standards. Each submission reflected the experience, concerns and expertise of the respondent and they build up into a relatively coherent package of views. To give a specific example, while IPMI lobbied hard for more science the PPI respondents did not argue for less science. There were no completely mutually exclusive comments here, other than the impossibility of accommodating all the suggestions into one 5 year educational experience.
1.5 Question 2. [OSPAP standards]: Overall, are the 10 standards fit of purpose?

Question 2: OSPA Standards - Overall, are the 10 standards fit for purpose?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>69.0%</td>
<td>255</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>7.0%</td>
<td>26</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

answered question 253
skipped question 17(5%)

Comments

Clear majority in favour.

Almost all the substantive comments made here were to argue that the standards must be the same between the OSPAP and the MPharm. Comments from Question 1 should be carried over to Question 2. The one specific comment about the OSPAP made here was the apparent lack of any first aid training in it (although this is covered in pre-registration).
1.6 Question 3. [Future pharmacists]: Are the individual standards fit for purpose?

Future pharmacists - Are the individual standards fit for purpose? Please comment on as many of the standards as you want.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>answered question</td>
<td>312</td>
</tr>
<tr>
<td>skipped question</td>
<td>58</td>
</tr>
</tbody>
</table>

Comments

Respondents commented on each of the individual standards. Most points were, however, not requests to alter a standard but comments on it or requests for elaboration. Most of the requests for elaboration can be dealt with with reference to other documents. In the covering paper for this item, there is a comment responding to every point made below.

Standard 1 – Patient and public safety

The overwhelming response was supportive of the proposals - other than a few counsels of despair that patient and public safety could never be guaranteed whatever steps GPhC took.

The PPI respondents did not seek to try to engage with some of the more technical standards (e.g. support for academic staff) later on but were very pleased to have the opportunity to talk about patient safety where they felt they had informed views and expertise. It is noteworthy that all the PPI seminars raised issues under this Standard about basic skills (e.g. record keeping, awareness of particular conditions or communications skills to name just three).

Academic responses were looking at higher level and more abstract issues. Each sector, therefore, played to its strengths rather than making mutually exclusive responses.

Some very specific reservations and/or points raised – mostly by the academic sector - included:

- Practicality issues in implementation.
- The balance between students’ and patients’ rights in the area of students’ health.
- Consistency between the SoPs.
- Squaring the circle between placing students in challenging (and hence learning) situations and never letting them work beyond their competence.
- Policies relevant to a work place in the preregistration year might not fit with a learning environment in a university. Implications of the MPharm being a guarantee of fitness to practise in the preregistration year.

Standard 2 – Monitoring, review and evaluation of initial education and training

While the proposals enjoyed support, there was a small body of much more critical comment here from the academic sector about the need for more clarification.
The generality of responses, though, greatly welcomed the inclusion of the public and patients, even if not all were sure how this could best be achieved. Several respondents called for a major training programme for this activity. The community pharmacy sector asked for employers also to be written into this standard.

Amongst other issues raised were:

- Resource implications and implementation queries.
- Training programme for PPI involvement in courses.
- Would patient feedback be better sought at a national or local level?
- The proposals needed to differentiate better between the MPharm and the preregistration year.
- The standard must not lose sight of the need for expert pharmacists’ input into review.
- Appropriate techniques at appropriate stages and the right balance in the assessment diet overall.
- More explicit accounts of what is to be measured, by whom and in what way.
- Care needed in using student and trainee feedback to make course changes.
- Use of the term ‘holistic’ evaluation

Standard 3 – Equality, Diversity and Fairness

This standard also attracted almost universal support, but there was a strong minority view among the (academic) supporters who queried if GPhC, as regulator, needed to play so active a role when so many other bodies – and the universities themselves not least – also had explicit duties. (NB. CUHOP acknowledged this but then pointed out the value of explicit reassurance to the public in this area).

Amongst other comments made were:

- Risks of burden and duplication.
- Issues around plain English should be located here.
- Need to correlate it with other standards. Comment:
  - There might be adverse implications for preregistration tutors who were not so well supported here as SoP staff.
- Rapport with patients.
- Translation/interpretation requirements of patients.
- Need for regular E & T updates

Two respondents specifically asked for this standard to be amalgamated with Standard 4.

The PPI input stressed that this standard as it affected patients had to be underpinned by pharmacists’ ability to establish rapport with them (see above). This carried the discussion into areas such as empathising with patients (however challenging), equity of treatment between different patients and groups of patients, communications skills and patients’ confidence in the pharmacist’s core skills. The PPI respondents often raised issues about translation and interpretation here, but this about the delivery of (NHS) services more generally and not one relating to the standards for initial pharmacy education and training.

Standard 4 – Selection of Students and Trainees
There was clear support for the principles underlying the proposals, although some queried whether the regulator was the most appropriate body to implement them. The balance between sectors was that all, again, played to their strengths. The PPI input looked at the professionals who would emerge eventually as a result of selection procedures while the academics had expert views to offer on the procedures themselves.

The academics raised two very particular points here. The first was whether the implications of this standard pointed towards mandatory interviews for all MPharm applicants (and BPSA lobbied hard for this), and the second was whether an explicit test of numeracy was needed. (This was then extended into the query as to whether a calculations paper should be set for entry to preregistration training in England and Wales).

Comments:

- Regulator's role in admission and selection.
- Mandatory interviews for admission.
- Mandatory numeracy tests for admission.
- Whether all applicants should be interviewed?
- The admissions role in creating professionals.
- Will this standard lead in the direction of uniformity (based on GPhC directions) for all SoPs?
- Equity of opportunity for preregistration trainee applicants needed to be maintained.
- Would selection criteria also have to be applied to access to MPharm clinical placements?
- Consistently full information needed to be given to all MPharm applicants to all SoPs.
- There was no point in allowing an applicant to start an MPharm who could not deal with difficult patients in due course and this should be assessed for.
- Maintaining equity in applications between GB, OSPAP and EEA groups. Involve professionals (e.g. social workers) in selection procedures (a PPI suggestion).

Standard 5 – Curriculum delivery and the student experience

The standard was accepted very widely as a basis for implementation and development. Most respondents felt that there could be more flesh on the bones here. In contrast, other – especially academic – responses counselled against being too prescriptive.

Although they offered some comments on this standard, the PPI seminar attendees – not surprisingly – could not claim the same level of detailed insight and expertise as they had for some earlier standards.

Academics were concerned about standard 5.10, which requires students to fail if they demonstrate unsafe practice.

NB CUHOP did not comment on this standard (or the following two).

Standard 6 – Support and development for students and trainees

Very few narrative responses were received, and most of them were about how it correlated with the other standards or with the overall five/two year experience. This made it one of the standards accepted with least query or reservation.
The largest area of concern was expressed for those students unable to progress to the preregistration year for reasons other than just failing the MPharm.

Several respondents commended the consistency in applying this standard across all environments.

More could be said here about inter-professional learning and working.

Standard 7 – Support and development for academic staff and preregistration tutors

This standard attracted greater explicit support than 5 or 6, and, again, its basis was unarguable, from the point of view of respondents.

There was, though, a great deal of comment in detail starting with three (academic) respondents dismissing it as patronising and irrelevant as a GPhC standard. The irrelevance referred to a perceived duplication with universities’ existing procedures here and an inappropriate departure from the regulator’s proper functions, although a counter argument was that the regulator staking a claim to this territory would strengthen MPharm course authorities’ hands. There was a body of opposition to the perceived distinction being drawn in this standard between pharmacist and non-pharmacist teaching staff.

Among other more detailed comments were:

- Pre-reg comment: This, and standard 4, were the two where Scottish respondents felt that NHS Education Scotland’s provisions meant they were already in compliance with the proposals, but the corollary being to ask how GPhC envisaged implementation in England and Wales. One academic respondent and two PPI seminars identified this standard as being where inter-professional working and “joined-up care” should reside.
- One respondent felt that the issue of staff:student ratios needed exploring here. There should be stronger links to CPD.

Standard 8 – Management of initial education and training

Respondents felt that this standard was appropriate and to be expected.

Few of the PPI seminars addressed it in any detail.

The big issue raised by many academic respondents here was resource implications if this standard, and the others more generally, were extended to clinical placements and preregistration training.

Meticulous application of this standard to short placements within the MPharm could be an “overkill” and a disincentive to developing them. Allowing the SoPs greater flexibility than the standard implied might also help address resource problems.

BPSA argued for a minimum level of clinical exposure in the MPharm to be set within this standard.

The role of other stakeholders was not discussed in the proposals and this was felt to be a lack.
Standard 9 – Resources and capacity

All respondents agreed with the proposition that pharmacy initial education and training should be adequately resourced. The PPI respondents, when they addressed this standard, contextualised it into general concerns about resource reduction in health and education.

More than any other one standard, academic respondents queried the definitions and criteria being used for this standard. In general this related to the use of terms like ‘appropriate’ and ‘adequate’.

The resource constraints for universities generally and MPharms in particular were a recurrent theme in the responses.

Amongst more detailed comments were:

- One respondent felt that this standard had to be supported by workforce planning.
- The standard had to be linked to quality issues, not just numerical ones. Comment:
- This standard begged the whole question of the funding regime(s) for pharmacy initial education and training, and GPhC could not set realistic standards without reference to this.
- The standard would be undeliverable without strong professional leadership.
- The specific roles of pharmacists in initial education and training needed to be elaborated together with their need to be qualified teachers in Higher Education – just pharmacists or just well qualified teachers were not enough to meet this standard.
- Do staff:student ratios need to be addressed under this standard (as well as under standard 7)?

Standard 10 – Learning outcomes

Only one respondent expressed fundamental reservations about the proposals as an appropriate point of departure. Few of the PPI seminars discussed this standard.

The answers elsewhere about there not being sufficient acknowledgement of science in the curriculum were reflected in those respondents’ comments on LOs.

CUHOP commented that this standard was different from the others.

Specific queries and comments included:

- Would this standard supersede the current preregistration Performance Standards?
- The LOs seemed more appropriate to practice than to pure science learning.
- Can safe and effective practice be assessed effectively as an LO?
- LOs should be mapped onto the indicative syllabus and the preregistration performance standards and take account of levels (in the QAA qualifications framework).
1.7 Question 4. [OSPAP standards]: Are the individual standards fit for purpose?

Question 4: OSPA standards - Are the individual standards fit for purpose?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>82.0%</td>
<td>206</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>3.0%</td>
<td>8</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td>34</td>
</tr>
</tbody>
</table>

answered question | skipped question | 214 | 36(13%) |

Comments

Unlike Question 3, some respondents felt that they were able to give a global response to this question, largely along the lines of the overall package for the OSPA having to be the same as for the MPFham. The endorsement here reflects the general satisfaction with the proposals on the assumption that the proposed MPFham standards will be translated into the OSPA. Concern was expressed from all sectors about OSPA graduates' communications skills. This was, in fact, the subject of research in 2010 and action taken in recent years does seem to have addressed this issue. (Note: the English language entry requirement was raised to 7.0 or above in each section of the academic version of IELTS in one sitting.)
1.8 Question 5. [Both documents]: Are we right to emphasise the importance of assessment and feedback?

![Bar chart showing responses to the question]

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>82.0%</td>
<td>305</td>
</tr>
<tr>
<td>No</td>
<td>1.0%</td>
<td>1</td>
</tr>
<tr>
<td>Unsure</td>
<td>2.0%</td>
<td>6</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td>39</td>
</tr>
</tbody>
</table>

*Answered question: 311
Skipped question: 59 (16%)*

**Comments**

Substantial majority in favour.

There was almost universal support for this proposition from among those who addressed the issue. The comments made were about refining it:

- need to ensure the appropriateness of the assessment technique at each stage,
- avoid duplication with universities' own procedures here, and
- there was room for improvement in this area by all the parties who assess and feed back to students.
1.9 Question 6. [Future Pharmacists]: Do you agree with our position on research in the MPharm?

![Bar chart showing the responses to the question.]

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>77.0%</td>
<td>193</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>8.0%</td>
<td>20</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td>50</td>
</tr>
</tbody>
</table>

**Comment**

Substantial majority in favour.

No one disagreed with research being an important element at all relevant levels in the MPharm, but some 20 respondents expressed reservations about the meaning and implications of the proposal as drafted. Some seemed to have interpreted it as raising the spectre of removing research entirely from the MPharm. The vast bulk of the comment was detailed proposals on how best to include research in the curriculum.

Seminar attendees were of the view that a research project should be retained as it could be the only opportunity for sustained effort and extended writing.

CUHOP commented on the need for a research environment in every school.
1.10 Question 7. [Future pharmacists]: Are the learning outcomes in Standard 10 set at the right level?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70.0%</td>
<td>174</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>24.0%</td>
<td>60</td>
</tr>
</tbody>
</table>

Comments

Clear majority in favour with ¼ of respondents unsure.

The preponderance of views here was supportive. The nature of this question did not attract outright "nos", but most of the respondents expressing concern returned to the theme of insufficient science in the curriculum. There were several narrative responses giving detailed information about how to make this standard more effective. BPSA specifically represented that Learning Outcomes must make the practitioner safe and effective on Day One.
1.11 Question 8. [OSPAP standards]: Are the learning outcomes in standard 10 set at the right level?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>69.0%</td>
<td>255</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>7.0%</td>
<td>26</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

Clear majority in favour.

Numerically, and for obvious reasons, this question had the same values as Question 4, but comments were made to carry this into the qualitative specifics of the question – particularly in the light of the OSPAP only being a quarter of the length of the MPharm. The issue of first aid in the OSPAP featured again here.
1.12 Question 9. [Future pharmacists]: Are the learning outcomes sufficiently comprehensive?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70.0%</td>
<td>174</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>22.0%</td>
<td>56</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td>42</td>
</tr>
</tbody>
</table>

answered question 234
skipped question 16 (6%)

Comments

Clear majority in favour with ¼ unsure.

Most of the support for this proposal is inferred rather than explicit, but it was supported in the seminar discussions. Those engaging with the question on-line tended to raise issues around definitions and clarity without committing themselves to challenging the underlying concepts. The concerns about the proposals being too focused on the clinical sector, and not having enough emphasis on science, re-emerged here. In particular, CUHOP commented that the learning outcomes would not be as suitable for the pharmaceutical industry as for community/hospital practice. However, CUHOP notes further ‘...that science is flagged up in the Science into practice section of the document, the indicative syllabus and in the EU directive...’.
Question 10. [OSPAP standards]: Are the learning outcomes sufficiently comprehensive?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>69.0%</td>
<td>255</td>
</tr>
<tr>
<td>No</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Unsure</td>
<td>7.0%</td>
<td>26</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

Clear majority in favour.

Numerically, and for obvious reasons, this question had the same values as Question 4, but comments were made to carry this into the qualitative specifics of the question. A number of respondents made the observation that as a group OSPAP graduates tended more towards clinical practice than to science. This had the effect of raising fewer queries here about the amount of science in the curriculum.
Question 11: [both documents]: Do you agree that the indicative syllabi give sufficient prominence to relevant science?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>44.0%</td>
<td>111</td>
</tr>
<tr>
<td>No</td>
<td>1.0%</td>
<td>1</td>
</tr>
<tr>
<td>Unsure</td>
<td>44.0%</td>
<td>111</td>
</tr>
</tbody>
</table>

Comments

A split between positive responses and unsure responses.

The split here reflects the underlying dichotomy between pharmacy as a science and pharmacy as a (clinical) healthcare profession. There is clearly concern that the role of science is being down-played and this question allowed that concern to be voiced more clearly than in any other context. It is notable, though, that as many people thought science was being given sufficient prominence as wished to explore this issue further.
Question 12 [Future pharmacists]: Is the indicative syllabus fit for purpose?

Future pharmacists - Is the indicative syllabus fit for purpose?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94.0%</td>
<td>350</td>
</tr>
<tr>
<td>No</td>
<td>1.0%</td>
<td>3</td>
</tr>
<tr>
<td>Unsure</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Comment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

Substantial majority in favour.

This question proved the most difficult to address. Its intent was clear in the seminars, but most of the answers submitted separately did not directly address the issues on which GPhC was seeking views.

Only two respondents endorsed the current indicative syllabus as being indefinitely fit for purpose without change or revision. (And this is a response which creates problems all of its own). For the remaining respondents the data presented here looks behind the initial reaction most respondents seem to have offered in order to interpret how their comments align with the consultation as a whole – and therefore remain consistent between the questions.
All but three of the respondents framed their answers (or engagement with the consultation process) in such a way as to endorse an indicative syllabus as being fit for the purpose of specifying the knowledge content of the MPharm and OSPAP in the context of the proposed new standards. All but five respondents then went on to suggest, or contribute to discussion on, what should be included in any review of the current indicative syllabus, but making it very clear that the current indicative syllabus, if left unreviewed, would not be fit for purpose into the future.

One comment in particular illustrated the approach many respondents took, “The syllabus outlined seems to ratify where pharmacy is now rather than reflect the future of the profession .......”. The analysis here acknowledges this, and other similar views, and then moves on to look at how they fit into the wider context of the consultation.
Question 13 [OSPA standards]: Is the indicative syllabus fit for purpose?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94.0%</td>
<td>350</td>
</tr>
<tr>
<td>No</td>
<td>1.0%</td>
<td>3</td>
</tr>
<tr>
<td>Unsure</td>
<td>0.0%</td>
<td>0</td>
</tr>
</tbody>
</table>

Comment

Substantial majority in favour.

Logically, the same considerations were applied here as at Question 12 and the data is presented on that basis. The qualitative difference is that many respondents went on to make helpful suggestions specific for the context of the OSPA.
Question 14: Any other comments

<table>
<thead>
<tr>
<th>Question 14: Are there any other comments you would like to make?</th>
<th>Answer Options</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>answered question</td>
<td>320</td>
</tr>
<tr>
<td></td>
<td>skipped question</td>
<td>50</td>
</tr>
</tbody>
</table>

Comment

Taking all the academic and PPI contributions from the seminars into account, some 320 or so people engaged with this question, and, if not all making a specific individual submission, did greatly contribute to the debate and outcome and to taking stock of the exercise as a whole.

A real value in this question was to promote a sense of inclusiveness and listening into the consultation. Particularly at the seminars, where most attendees had not engaged with a pharmacy regulator before, there was a sense of the door being open for the public to make comments and to be heard.

Overall, the contributions here reinforced the tone of submissions made against earlier questions. Many of the on-line respondents repeated answers to earlier questions to give them added force. Many respondent raised issues here not relevant to the consultation (e.g. car parking fees while visiting a hospital pharmacy) and these have not been recorded for this report.

There were some new topics raised here, and these included:

- continuing to keep clinical and theoretical education separate (as it is currently perceived to be),
- using the proposed standards to facilitate greater mutual recognition with non-EEA countries,
- more discussion of the future pharmacy workforce and its needs,
- using the revised standards as a platform for lobbying for revision of the Pharmacy Directives,
- the need to move away from relying on good will to provide resources for the preregistration year, and
- how will the proposals stand up to changes in the NHS and the roles of bodies such as the National Institute for Clinical Excellence.
Question 15: Do you have any other comments you wish to make about the content of the standards for education and training for pharmacists?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>answered question</td>
<td>10</td>
</tr>
<tr>
<td>skipped question</td>
<td>58</td>
</tr>
</tbody>
</table>

Comment

A number of respondents took this opportunity to reflect on the whole exercise, but without raising new topics. Although there were also adverse remarks made, the single most positive comment about the consultation was made here, “We are very pleased to see the new standards and think they herald a fresh approach to thinking about this critical initial formation”.

Final comment

In response to all the questions, respondents asked for additional clarity on particular issues and explanations of intentions. There was no particular pattern in the requests.

Prepared by

Dr Peter Burley, Independent Consultant
21 April 2011