General Pharmaceutical Council

Analysis report of the consultation about the education and training of pharmacist independent prescribers: what we did

1. Policy background

1.1. Between March and June 2018, we consulted on changes to the education and training standards for pharmacist independent prescribers. Pharmacists have been independent prescribers since 2006, but it is in the last five to six years that the demand and opportunities for pharmacist independent prescribers have increased quickly. In that time, there has also been a change in the profile of pharmacists who are training to become independent prescribers.

1.2. In the consultation, we explained that alongside an increase in the number of pharmacist independent prescribers, the prescribing role has developed significantly in recent years. When it began, pharmacist independent prescribing was based on quite narrow specialisms, but we have learnt that pharmacists have broadened their roles once they have qualified[1]. Many are now working as generalist prescribers in GP practices, emergency departments, online and in other settings. In many cases this is in direct response to government initiatives, for example the Scottish Government's intention to have a pharmacist independent prescriber in all GP practices.

1.3. We also learnt that pharmacists are choosing to become independent prescribers earlier in their careers. At first, interest was from pharmacists with several years of clinical practice experience, wanting to add prescribing to an already well-developed portfolio of clinical and diagnostic skills. More recently applicants have been younger pharmacists wanting to upskill at a much earlier stage in their careers.

1.4. As the demand for pharmacist independent prescribers has increased, course providers have been expanding their provision to keep up with demand. As the regulator, we have a responsibility to make sure that this provision is fit for purpose, and this was the purpose of the consultation.

1.5. In the light of these changes, we consulted on improvements to the education and training standards for pharmacist independent prescribers to make sure courses are fit for purpose and that the learning outcomes included in the standards are clearly focused on the current prescribing role.

[1] See GPhC **Prescribers Survey Report** (2016)

2. Summary of our proposals

2.1. Having reviewed our standards and current requirements, we proposed three key changes to the education and training of pharmacist independent prescribers.

2.2. Firstly, we proposed to remove the current requirement that course applicants must have worked in a patient orientated role for two years to enter an independent prescribing course. This requirement would be replaced by an application process in which an applicant's experience is verified to ensure that they are ready to train. We proposed this because we have heard that there is too much emphasis on the time requirement and not enough emphasis on relevant knowledge and skills. Also, we have no evidence to suggest that 'time served' produces applicants of the right quality to train.

2.3. Secondly, we consulted on revised learning outcomes for independent prescriber courses which will describe the knowledge and skills a trainee will have on successful completion of a course. The learning outcomes are general, not specific, and the knowledge and skills in them can be applied in any prescribing area. This means that courses may choose to focus on a relatively narrow, specialist area, or on broader ones, such as general practice or accident and emergency. This reflects the reality of contemporary prescribing practice and brings these standards into line with contemporary practice and our other standards, which emphasise outcomes.

2.4. Finally, we proposed to introduce 'designated prescribing practitioners'. At the moment, only doctors are allowed to formally supervise trainees as designated medical practitioners. We proposed that in future, pharmacists training to be independent prescribers could be supervised formally not only by doctors, but also by experienced pharmacist prescribers and other experienced prescribers.

3. About the consultation

3.1 Overview

3.1.1. The consultation was open for 12 weeks, beginning on 14 March and ending on 6 June. To ensure we heard from as many individuals and organisations as possible:

- an online survey was available for individuals and organisations to complete during the consultation period. We also accepted postal and email responses.
- we organised a series of stakeholder engagement events aimed at pharmacy professionals, pharmacy service users, organisations and other interested parties.
- we promoted the consultation through a press release to the pharmacy trade media, via our social media and through our online publication *Regulate*.

3.2 Survey

3.2.1. We received **399** responses to the survey. The vast majority of respondents had completed the online version of the questionnaire, with the remaining respondents submitting their response by email, using the structure of the consultation document.

3.2.2. Of those who submitted a written response, **340** were individuals and **59** were from organisations.

3.2.3. Alongside these, we received a small number of responses from organisations writing more generally about their views.

3.3 Stakeholder events

3.3.1. The questions in the online survey were also used as a structure for discussion in our stakeholder events, allowing us to capture people's views, and include them in our consultation analysis.

- We held three stakeholder events in London, Cardiff and Aberdeen, and spoke at the NES Conference in Scotland. These were attended by a mix of pharmacists (including pharmacist independent prescribers), people working in education and training, employers, and representatives from professional and trade bodies.
- We organised three patient focus groups, held in London, Cardiff and Glasgow.

3.3.2. **110** individuals and representatives of organisations participated in these events.

3.4 Social media

3.4.1. We monitored social media activity during the consultation period in which we were tagged or which used the consultation hashtag, and collated the feedback for inclusion in our consultation analysis.

3.4.2. During the consultation, two conversation threads were active accounting for about 20 posts in total.

4. Our approach to analysis and reporting

4.1. Overview

4.1.1. Every response received during the consultation period, including notes from stakeholder events and social media activity has been considered in the development of our analysis. Our thematic approach allows us to represent fairly the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events.

4.1.2. The key element of this consultation was a self-selection survey, which was hosted on the Smart Survey online platform. As with any consultation, we expect that individuals and groups who view themselves as being particularly affected by the proposals, or who have strong views on the subject matter, are more likely to have responded.

4.1.3. The purpose of the analysis was to identify common themes amongst those involved in the consultation activities rather than to analyse the differences between specific groups or sub-groups of respondents.

4.1.4. The term 'respondents' used throughout the analysis refers to those who completed the consultation survey and those who attended our stakeholder events. It includes both individuals and organisations.

4.1.5. For transparency, Appendix 1 provides a list of the organisations that have engaged in the consultation through the online survey, email responses and/or their participation in our stakeholder events[2].

4.1.6. The consultation questions are provided in Appendix 2.

[2] NB some organisations asked for the name of their organisation to remain confidential, and are not included.

4.2. Quantitative analysis

4.2.1. The survey contained a number of quantitative questions such as yes/no questions and rating scales. All responses have been collated and analysed including those submitted by email or post using the consultation document. Those responding by post or email more generally about their views are captured under the qualitative analysis only.

4.2.2. Responses have been stratified by type of respondent, so as not to give equal weight to individual respondents and organisational ones (potentially representing hundreds of individuals). These have, however, been presented alongside each other in the tables throughout this report. This is in order to help identify whether there were any substantial differences between these categories of respondents.

4.2.3. A small number (less than 5) of multiple responses were received from the same individuals. These were identified by matching on email address and name. In these cases, the individual respondent's most recent response was included in the analysis.

4.2.4. The tables contained within this analysis report present the number of respondents selecting different answers in response to questions in the survey. The ordering of relevant questions in the survey has been followed in the analysis.

4.2.5. Skipped answers have not been included. Cells with no data are marked with a dash.

4.2.6. Percentages have been rounded to the nearest % point; as a result, some totals will not add up to 100%.

4.3. Qualitative analysis

4.3.1. This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations, email and postal responses, social media activity and notes of stakeholder engagement events.

4.3.2. A coding framework was developed to identify different issues and topics in responses, to identify patterns, as well as the prevalence of ideas, and to help structure our analysis. The framework was built bottom up through an iterative process of identifying what emerged from the data, rather than projecting a framework set prior to the analysis on the data.

Analysis of consultation responses and engagement activities: what we heard

5. What we heard: views on the proposed learning outcomes

5.1. Agreement with outcomes

Table 1: Agreement with outcomes

To what extent do you agree that these are appropriate learning outcomes for a pharmacist independent prescriber in training?	**N and % individuals**	**N and % organisations**	**Total**
Strongly agree	183 (54%)	30 (51%)	213 (53%)
Partially agree	95 (28%)	16 (27%)	111 (28%)
Neither agree nor disagree	22 (6%)	1 (2%)	23 (6%)
Partially disagree	14 (4%)	5 (8%)	19 (5%)
Strongly disagree	24 (7%)	6 (10%)	30 (8%)
Don't know	2 (1%)	1 (2%)	3 (1%)
Total N of responses	**340 (100%)**	**59 (100%)**	**399 (100%)**

5.1.1. As reflected in table 1, the majority of respondents agreed or strongly agreed that the outcomes were broadly appropriate, with little difference between organisations and individual respondents.

5.2. Gaps in the outcomes

Table 2: Perceived gaps in the outcomes

Is there anything missing from the learning outcomes in Part 1?	**N and % individuals**	**N and % organisations**	**Total**
Yes	52 (15%)	30 (51%)	82 (21%)
No	176 (52%)	23 (39%)	199 (50%)
Don't know	112 (33%)	6 (10%)	30 (30%)
Total N of responses	**340 (100%)**	**59 (100%)**	**399 (100%)**

Table 3: perceived gaps in the outcomes: breakdown by domain

Is there anything missing from the learning outcomes in Part 1?	**N and % individuals**	**N and % individuals**	**Total**

(NB respondents could identify multiple domains or none)			
Professional knowledge and skills	33 (10%)	17 (29%)	50 (13%)
Person-centred care	14 (4%)	16 (27%)	30 (8%)
Professionalism	11 (3%)	18 (31%)	29 (7%)
Collaboration	9 (3%)	14 (24%)	23 (6%)
Other (please specify):	15 (4%)	9 (15%)	24 (6%)
Total respondents	**340**	**59**	**399**

5.2.1. Just over half of individual respondents thought that there were not any gaps in the learning outcomes. A similar percentage of organisational respondents, however, thought that there were things missing from the outcomes.

5.2.2. Not all respondents who identified a gap gave a comment identifying the specific issue missing. Some respondents also made comments that were relevant to other areas of the consultation instead.

5.3. Gaps in professional knowledge and skills

5.3.1. In their comments, respondents identified gaps most frequently in the professional knowledge and skills domain. Key gaps or areas that required greater focus identified under this domain were:

- clinical and examination skills-respondents felt there should be clearer requirements around developing skills in physical clinical examinations.
- public health issues, health promotion and prevention: some respondents suggested this should be included more explicitly, or that the outcomes should make it clear that pharmacist independent prescribers should not only consider 'the patient in front of them' but public health in general
- using information: pharmacy professionals and organisational respondents suggested the outcomes should include identifying and use up to date information, and doing so accurately
- confidentiality and safeguarding information, which were raised by patients in particular

5.4. Gaps in person-centred care

5.4.1. Respondents suggested that there were areas where person-centred care could be better emphasised. Respondents raised two linked issues:

- that the outcomes could better support the development of clinical and consultation skills including more emphasis on two-way communication and listening to patients, and clinical decision-making skills could be given more emphasis
- that the language around decision-making did not reflect modern practice around consent and decision-making: several respondents pointed to parts of the outcomes where they considered it read as if the pharmacist independent prescriber made decisions for the patient, rather than in partnership with the patient

5.4.2. While not a gap as such, patients we spoke to consistently emphasised issues around trust, professionalism and confidentiality, as well as the knowledge and expertise of independent prescribers. They emphasised the need for in-depth clinical knowledge and wanted education and training to ensure that pharmacists were expert in medicines they prescribed.

5.5. Gaps in other areas

5.5.1. Some of the other ways of addressing gaps identified included:

- recognising the limits of competence, working within the confines of specialist area and referring appropriately
- greater focus on error prevention and detection, safety disciplines and 'human factors' likely to contribute to errors
- better coverage of mental health
- the inclusion of outcomes in relation to initiating, modifying and stopping prescribing
- skills and behaviours for working effectively as a member of a multi-professional team.

5.6. Areas for change in the outcomes

Table 4: Requests for change to the outcomes

Is there anything in the learning outcomes in Part 1 that should be changed?	**N and % individuals**	**N and % organisations**	**Total**
Yes	49 (14%)	28 (47%)	77 (19%)
No	205 (60%)	27 (46%)	232 (58%)
Don't know	86 (25%)	4 (7%)	90 (23%)
Grand Total	**340**	**59**	**399**

5.6.1. Most respondents thought the outcomes did not require further change. However, responses to this question differed between individuals and organisations: while individuals largely did not see any need to make changes, organisations identified several issues where they considered further changes were required. In most, but not all, cases these respondents saw the outcomes as appropriate overall.

5.7. Requests for changing: raising the level of the outcomes

5.7.1. Several respondents used their comments to suggest that the level of the outcomes should be changed to require more demonstrations of competence. Many respondents wanted to see the level of some of the outcomes raised to 'does' as opposed to 'knows how', with some suggesting that all the outcomes should be set at the level of 'does'.

5.7.2. While many respondents agreed that outcomes should be demonstrated at a higher practical level, several suggested that it was not always possible to do so at the level of 'does', as opportunities might not arise during a training programme. They suggested these outcomes should be set at 'shows how', which could be tested more feasibly during the course.

5.7.3. A theme in some organisational respondents suggested that the outcomes were not always written in a way that was appropriate to level 7 (masters' level) programmes. For example, some suggested 'understand' was not appropriate and that the outcomes should require higher levels of attainment.

5.8. Support for generalist learning outcomes

5.8.1. Respondents to the consultation made few comments about the balance between generalism and specialism, but there was strong support for the learning outcomes being general in nature, as:

- this was a more educationally sound approach
- individual courses would not cover the detailed knowledge for all areas of specialist practice
- this aligned better with government policy in Scotland

5.8.2. A small number of respondents disagreed and stated that learning outcomes should reflect the individual needs of the particular area of specialist practice of the learner.

5.9. Requests for change: changing areas of specialism

5.9.1. Respondents also questioned what would happen when an individual prescriber's specialist area changed or expanded and suggested there needed to be safeguards around this. Suggestions included induction to the new specialist area, shadowing a GP, or completing postgraduate modules.

5.9.2. Some respondents wanted it to be made clearer that providing generalist clinical care of patients could be considered an area of specialisation.

5.10. Rationale for disagreement with the learning outcomes framework

5.10.1. The learning outcomes we consulted on were adapted from the Royal Pharmaceutical Society's (RPS) **Competency framework for all prescribers** and modified to reflect expected practice immediately following annotation, as opposed to describing the capabilities of experienced prescribers (which are described in the RPS framework). Most respondents felt the learning outcomes made appropriate links to the RPS framework. However, some respondents thought not all aspects of the RPS framework were included in the learning outcomes, and suggested it would have been better to adopt the RPS framework as:

- this had been done successfully for independent prescribers in other professions (e.g. nursing)
- having separate outcomes could be detrimental to multidisciplinary education and working
- it might create inconsistent standards of competency between independent prescribers from different professions.

5.11. Requests for clarification of policy issues and wording

5.11.1. In terms of the point at which learning outcomes were demonstrated, several respondents suggested that the section should be amended to indicate that they should be achieved by the end of the course.

5.11.2. Respondents noted examples where the wording used in the learning outcomes could be improved to reflect wider policy issues. Respondents suggested referring to 'practice' rather than prescribing, as decisions not to prescribe were also important. Some respondents also suggested the range of roles/actions under 'prescribing' should be clearer.

5.11.3. Respondents also suggested a number of changes to reflect more widely understood terminology, changes to wording they felt to be ambiguous, and the use of more consistent language. They also suggested other presentational or editing changes to make the learning outcomes clearer[3].

5.11.4. Several respondents identified duplication and repetition in the learning outcomes and suggested the number of outcomes could be reduced. Examples included overlap between learning outcomes related to legal and ethical frameworks around prescribing.

6. What we heard: views on the standards for independent prescriber course providers

6.1. Agreement that the standards are appropriate

Table 5: Agreement with standards

Considering the full set of standards and criteria in Part 2, to what extent do you agree that these are appropriate standards for a pharmacist independent prescribing course?	**N and % individuals**	**N and % organisations**	**Total**
Strongly agree	174 (51%)	27 (46%)	201 (50%)
Partially agree	103 (30%)	18 (31%)	121 (30%)
Neither agree nor disagree	21 (6%)	-	21 (5%)
Partially disagree	11 (3%)	8 (14%)	19 (5%)
Strongly disagree	27 (8%)	4 (7%)	31 (8%)
Don't know	4 (1%)	2 (3%)	6 (2%)
Grand Total	**340**	**59**	**399**

6.1.1. Support for the standards in general was high across both organisations and individual respondents.

6.2. Gaps in standards

Table 6: Items missing from the standards

Is there anything missing from the standards or criteria in Part 2?	**N and % individuals**	**N and % organisations**	**Total**
Yes	46 (14%)	33 (56%)	79 (20%)
No	198 (58%)	23 (39%)	221 (55%)
Don't know	96 (28%)	3 (5%)	99 (25%)
Grand Total	**340**	**59**	**399**

[3] NB we will review these individually when redraft the learning outcomes.

Table 7: Items missing from the standards- breakdown by domain

In which of the following areas do you think there is something missing? (Please tick all that apply) (NB respondents could select multiple domains or none)	**N and % individuals**	**N and % organisations**	**Total**
Domain 1 – Selection and entry requirements	28 (8%)	22 (37%)	50 (13%)
Domain 2 – Equality, diversity and inclusion	1 (0%)	7 (12%)	8 (2%)
Domain 3 – Management, resources and capacity	5 (1%)	15 (25%)	20 (5%)
Domain 4 – Monitoring, review and evaluation	7 (2%)	11 (19%)	18 (5%)
Domain 5 – Course design and delivery	11 (3%)	10 (17%)	21 (5%)
Domain 6 – Learning in practice	13 (4%)	15 (25%)	28 (7%)
Domain 7 – Assessment	9 (3%)	11 (19%)	20 (5%)
Domain 8 – Support and the learning experience	5 (1%)	11 (19%)	16 (4%)
Domain 9 – Designated prescribing practitioners	17 (5%)	28 (47%)	45 (11%)
Other	3 (1%)	3 (5%)	6 (2%)

6.2.1. Less than a quarter of respondents identified elements missing from the standards, but this included a majority of the organisations who responded to the consultation. Respondents identified the most gaps in relation to Domain 1 – Selection and entry requirements - and Domain 9 – Designated prescribing practitioners. These were the subject of specific questions which are considered in more detail below.

6.2.2. Aside from issues around domains 1 and 9, respondents raised particular issues around the resourcing and learning in practice domains. In many cases, there was not a clear distinction between gaps and suggestions for change.

6.3. Gaps in resourcing: staffing and protected time

6.3.1. Respondents were supportive of requirements around the staffing of independent prescriber courses, with some seeing it as a way to improve the clinical relevance of courses. While supportive, some raised practical questions about the requirement to involve pharmacist independent prescribers in the development of courses; they questioned whether this would have impact for independent prescribing courses run on multidisciplinary lines and suggested these providers may need time to adjust.

6.3.2. Other comments received around staffing and resourcing included that:

- staffing requirements should ensure that staff with experience of delivering care were involved in the delivery of the course.
- it would be helpful to involve recently qualified prescribers in the design of courses.

6.3.3. Respondents also suggested that the requirements should be stronger in terms of:

- Providing protected time in learning in practice settings, as this was difficult for course providers to enforce
- ensuring course providers developed learning resources that were matched to the learning environment and areas of practice they were teaching.

6.4. Gaps in assessment

6.4.1. Comments on assessment focussed on similar themes to those raised around the learning outcomes (see 5.7 above), with many respondents suggesting that practical demonstrations of competency were required as part of the assessment.

6.4.2. Other suggestions were:

- the addition of a further criterion to assessment requirements covering the clinical effectiveness of prescribing
- strengthened requirements to ensure the consistency of assessment across providers
- more guidance on the minimum content of assessment and of assessment regulations

6.5. Gaps in requirements around multidisciplinary education

6.5.1. A frequent theme across many different parts of the consultation was learning with and from a range of other prescribing professionals, particularly doctors. Some of these respondents said this could be achieved by putting greater emphasis in the standards on learning in multidisciplinary environments.

6.6. Other gaps: requests for detail or process descriptions/requirements

6.6.1. A small number of respondents suggested the provision of descriptions or examples of some aspects of the standards. This was particularly in relation to entry requirements and designated prescribing practitioners (see below), but also for other areas including managing unsafe practice and supervision.

6.6.2. Several respondents also suggested that the standards should be clearer about the allocation of responsibility for different aspects of the course, especially between course providers and designated prescribing practitioners.

6.6.3. Respondents also highlighted where they felt the standards should do more to mandate particular approaches or processes. Examples, mostly from independent prescribing course providers, included requests for a wording used for final sign-off of the trainee and policies on resitting assessments or monitoring attendance.

6.6.4. Some respondents also questioned the need for requirements around fitness to practise processes, noting that pharmacist independent prescriber trainees would already be registered pharmacists.

6.7. Requests for changes to standards

Table 8: Requests for changes to the standards

Is there anything in the standards or criteria in Part 2 that should be changed?	**N and % individuals**	**N and % organisations**	**Total**
Yes	62 (18%)	30 (51%)	92 (23%)
No	193 (57%)	26 (44%)	219 (55%)
Don't know	85 (25%	3 (5%)	88 (22%)
Grand Total	**340**	**59**	**399**

6.7.1. A majority of respondents did not think changes to the standards were needed, although a majority of organisations supported changes.

6.7.2. For organisations, a key theme across all the domains (and the consultation generally) was the responsibilities placed on course providers. These were seen as onerous or difficult to implement, particularly in relation to domain 6 (learning in practice), and domain 3 (management and resources).

6.8. Requests for changes: learning in practice and course providers' ability to influence this

6.8.1. Some organisations used their free text comments to express concern about their ability to manage the quality of learning in practice. They commented that:

- they would struggle to implement a learning agreement that would cover the learning in practice location (and the designated prescribing practitioner)
- they would be able to exert little or no control over the trainee's workload
- they would find it difficult to monitor or act on quality monitoring criteria around the learning in practice placement or assessments conducted in this environment.

6.8.2. Respondents, especially organisations, also said that to meet requirements around quality outside the course provider's location would involve substantial investment in quality management processes which universities may not be prepared to support. Some respondents also suggested the forms of quality management may be intrusive in the learning environments themselves.

6.9. Requests for changes: providing clarity and addressing ambiguity

6.9.1. As with the learning outcomes, respondents to the consultation frequently requested more clarity or detail in the standards, or wanted to see the number of standards reduced. Specific issues included:

- areas where they thought the standards were repetitious or could be merged
- items which were redundant as they were covered by professional regulations or would be covered by regulation within the course provider themselves.
- areas where respondents thought the wording used was unclear, inconsistent or where more explanation was required. Examples included: terminology around consultation skills and requests to clarify statements, particularly in relation to supervision
- reflecting the legal rights of trainee prescribers to prescribe more accurately in some places

6.10. Other issues raised in comments

6.10.1. Several respondents to the consultation questioned how standards would be assured and emphasised the need for robust quality assurance in general. Some respondents specifically suggested GPhC quality assurance should be more rigorous.

6.10.2. Some respondents suggested that it was not appropriate to require course providers to take the guidance on tutoring into account, as it was too generic for independent prescribing courses or needed to be updated to reflect the needs of these courses.

6.10.3. Some respondents asked for more guidance about how equality and diversity data should be used in the management of courses.

7. What we heard: views on proposals to change the entry requirements for independent prescribing courses

7.1. Views on entry requirements

Table 9: agreement with proposed changes to entry requirements

Should the current two-year time requirement for training be removed and replaced with a requirement for the suitability and relevance of an applicant's experience to be submitted and approved as part of the application process?	**N and % individuals**	**N and % organisations**	**Total**
Yes	166 (49%)	42 (71%)	208 (52%)
No	159 (47%)	12 (20%)	171 (43%)
Don't know	15 (4%)	5 (8%)	20 (5%)
Grand Total	**340**	**59**	**399**

7.1.1. The consultation proposed revised selection and entry requirements for independent prescribing courses. These would replace the previous requirements, which included that applicants must have two years post-registration experience, with an application process in which a pharmacist's experience is verified to ensure that they are ready to train as an independent prescriber.

7.1.2. Individual respondents were split evenly between removing the two-year requirement or not, although a large majority of organisations were in favour of the proposal.

7.2. Rationale for supporting the replacement of the two-year requirement

7.2.1. There were numerous comments agreeing with the proposal. Those agreeing said that:

- the reasons put forward in the consultation were convincing. Respondents particularly welcomed the emphasis on the knowledge and skills of the applicant on the grounds it would improve patient care
- it was positive to recognise that some pharmacists may be ready to become independent prescribers sooner (or later) than others
- the two-year requirement provided little guarantee of relevant experience

7.3. Rationale for disagreeing with the withdrawal of the two-year requirement

7.3.1. Reasons cited by respondents for keeping the two-year requirement (or retaining some kind of time requirement) were that:

- it helped to ensure prospective independent prescribers had experience of dealing with patients; some respondents commented that while it did seem arbitrary, it was still effective
- changing this requirement would lower standards for entry
- candidates with insufficient experience would apply to and be accepted onto courses

- In particular, respondents said pharmacists should not be able to enter an independent prescribing course straight after registration
- Some respondents thought course providers would be under pressure to fill places and this would result in lowering entry standards, or that entry requirements would not be upheld through regulation, and that this would make the application process ineffective

7.4. Suggestions to combine time- and competency-based approaches

7.4.1. A large minority of respondents supported putting the emphasis on the skills and knowledge of applicants, but also felt that the two-year requirement was an effective safeguard to ensure experience. They suggested that there should be both an application process *and* a two-year requirement.

7.5. Suggestions that the MPharm should (or must) change

7.5.1. Several respondents commented that undergraduate training needed to change to better prepare graduate pharmacists to become prescribers.

7.6. Demonstrating the entry requirements: requests for clarity and additional guidance

7.6.1. A large number of respondents commented that it was important for the GPhC to develop guidance on:

- developing and applying the entry requirements to their courses (many of these respondents felt this was important to ensure consistent entry requirements across the different courses)
- what constituted appropriate expertise for designated prescribing practitioners

7.7. Demonstrating the entry requirements: suggestions for evidence and prerequisites

7.7.1. Respondents to the consultation gave their views on what kind of evidence an applicant could provide to demonstrate they met the entry requirements of the course. Suggestions included:

- records of activity, such as portfolios, or work experience
- Revalidation records- a few respondents suggested focussing revalidation records on gaining the experience required in the years before making an application to an independent prescribing course would be good evidence of suitability
- a clear rationale for applying to an independent prescribing course, including a plan for how the skills gained in the course would be used subsequently
- external support for the application (for example feedback on performance or references)
- assessments of the applicant's clinical and communication skills
- completing a diploma qualification
- passing the Prescribing Safety Assessment (usually taken by final year medical students)

7.7.2. Some respondents also suggested that the applicant should present evidence that their working environment would be suitable to undertake the course, for example, by showing that they would receive protected time for learning.

7.8. Demonstrating the entry requirements: Community pharmacy

7.8.1. Several respondents commented that it may be difficult for community pharmacists to demonstrate the necessary experience required to participate in independent prescribing programmes. These respondents wanted to see entry requirements (and guidance) drawn up in such a way as to enable pharmacists working in community settings to demonstrate they could meet these requirements.

7.8.2. Some respondents noted the same concerns might also apply to locum pharmacists or those with unconventional or portfolio careers.

7.9. Other issues

7.9.1. Respondents also raised the following issues and questions for the GPhC in relation to entry criteria:

- whether course providers should check that applicants had not previously failed to complete an independent prescribing course as part of the application process
- whether there would (or should) be exemptions from some aspects of independent prescriber courses or entry requirements for pharmacists with particular experience or qualifications
- that course providers should provide feedback to unsuccessful applications

8. What we heard: views on proposals for Designated Prescribing Practitioners

8.1. Agreement with requirements for designated prescribing practitioners

Table 10: agreement with requirements for designated prescribing practitioners

Will Domain 9 ensure that only appropriately trained and experienced independent prescribers will be acting as designated supervisors for the learning in practice part of pharmacist independent prescribing programmes?	**N individuals**	**N organisations**	**Total**
Yes	199 (59%)	26 (44%)	225 (56%)
No	88 (26%)	29 (49%)	117 (29%)
Don't know	53 (16%)	4 (7%)	57 (14%)
Grand Total	**340**	**59**	**399**

8.2. Rationale for Supporting the introduction of designated prescribing practitioners

8.2.1. There was significant support for the development of designated prescribing practitioners in the consultation on the grounds that:

- they would provide appropriate support and supervision and were well placed to do so; some respondents who were independent prescribers commented they had benefited from having a pharmacist independent prescriber involved in their training
- there was no reason to bar pharmacist independent prescribers from supervising trainees, provided they were suitably experienced with relevant expertise.

- the supply of supervisors would be improved, enabling more independent prescribers to be trained
- it would empower and benefit the pharmacy profession and improve the training of pharmacist independent prescribers

8.3. Rationale for opposing the introduction of designated prescribing practitioners

8.3.1. Several respondents expressed opposition to designated prescribing practitioners, arguing that only doctors had the relevant experience and expertise in prescribing to be supervisors, or that pharmacists did not have the appropriate experience to act as supervisors

8.4. Rationale for modification of domain 9: multidisciplinary involvement in training

8.4.1. A theme across the consultation was that training should involve learning from other prescribing professions, and doctors in particular. A large proportion of respondents noted that the current arrangements ensured medical involvement in the training of pharmacist independent prescribers and wanted this to continue. Respondents who held this view told us that:

- doctors had important skills and experience to teach independent prescribers and should have a role in signing off a pharmacist independent prescriber at the end of their course
- independent prescribers should have exposure to, or shadow, doctors as part of their training

8.4.2. Some respondents were concerned that if independent prescribers were trained in a way which did not involve other clinicians, they could become isolated. This was seen to be problematic as:

- healthcare is increasingly delivered in a multi-professional way
- other professions might withdraw their support for the principle of pharmacist independent prescribers
- it might limit the opportunities available to pharmacist independent prescribers.

8.4.3. Some respondents envisaged an arrangement in which different professionals (including doctors) would contribute to training, supervision and assessment under the coordination of a supervisor, who could be a prescriber from any profession.

8.5. Rationale for modification of domain 9: requirements for designated prescribing practitioners

8.5.1. While there was overall support for the standards for designated prescribing practitioners, many respondents expressed reservations about aspects of the standards we set out for designated prescribing practitioner. Respondents raised two main issues:

- the need for more guidance about the core competencies and skills required to be designated prescribing practitioners, and the evidence that could be used to assess them
- several respondents suggested that there should be further requirements or criteria to meet in order to become a designated prescribing practitioner. Examples included:
    - assurance of fitness to practise/being in good standing with their professional regulator
    - a sufficient amount of time since qualification as a prescriber to develop the expertise required for supervision (some respondents suggested five years was appropriate)

- maintaining currency and demonstrating continuing competency through revalidation

8.5.2. A small number of respondents suggested that it would be helpful to require further support for designated prescribing practitioners in addition to that described in domain 9, for example refresher training or support in managing poorly performing trainees.

8.6. Rationale for modification of domain 9: onus on course providers

8.6.1. Several respondents questioned whether course providers would be able to meet some of the requirements in domain 9 (particularly 9.3-5), raising similar issues about capacity, influence and resourcing to those that were raised about the learning in practice domain (see 6.8). This reflected a theme across the consultation about what was seen as onerous responsibilities being introduced for course providers by the new standards.

8.6.2. Respondents, especially course providers, were concerned that they could do little to make requirements of, influence or support designated prescribing practitioners. They were critical of the requirements on course providers to:

- ensure designated prescribing practitioners engaged with training
- quality manage and provide feedback to designated prescribing practitioners
- providing mentors for new designated prescribing practitioners

8.6.3. Reasons cited for this criticism were that that course providers had little control or influence over designated prescribing practitioners' compliance with requirements, or that the requirements were unfeasible, too resource intensive or posed significant practical difficulties for course providers.

8.7. Barriers to becoming a designated prescribing practitioner

8.7.1. Some respondents suggested that some aspects of the standards were too restrictive, about who could act as a designated prescribing practitioner. These included:

- requiring designated prescribing practitioners to have experience of assessment and mentoring (as few pharmacists would have had opportunities to do so, and this could be addressed through training)
- requiring the supervisor to be closely matched to the specialist area in which the trainee wished to train- several course providers said that a designated medical practitioner working in a generalist area could provide appropriate supervision to a more specialist trainee

8.7.2. Many respondents also questioned what they saw as heavy requirements and responsibilities on designated prescribing practitioners and suggested these could make the role unattractive.

8.8. Other issues raised: Conflicts of interest and accountability for sign-off

8.8.1. Several respondents suggested the standards should explicitly discuss conflicts of interest in the choice of designated prescribing practitioner.

8.8.2. Some organisations also commented that the course provider's role in the final sign-off of the trainee pharmacist independent prescriber needed to be better recognised in the standards.

9. What we heard: the impact of our proposals

9.1. Impacts on protected characteristics

Table 11: Impact of standards on groups sharing protected characteristics

Do you think anything in the standards or proposed changes would impact – positively or negatively – on certain individuals or groups who share any of the protected characteristics listed above?	**N and % individuals**	**N and % organisations**	**Total**
Yes	20 (6%)	8 (14%)	28 (7%)
No	257 (76%)	44 (75%)	301 (75%)
Don't know	63 (19%)	7 (12%)	70 (18%)
Grand Total	**340**	**59**	**399**

9.1.1. Very few respondents identified impacts on the protected characteristics, although several identified significant impacts on other groups. These frequently reflected themes raised elsewhere in the consultation about resource impacts on course providers, and on community pharmacy.

9.2. Impacts identified: women from black and minority ethnicity (BAME) backgrounds

9.2.1. The largest group of comments on this issue focussed on the impact of additional costs to course providers from the standards, and suggested providers would pass the costs on to students, impacting on pharmacists who self-funded their training in particular. Some respondents suggested this would impact on those working part time, a group in which it was suggested there are a high proportion of women from BAME backgrounds. Respondents considered these groups might find it more difficult to access independent prescribing courses as a result. Some respondents suggested this might also affect students with disabilities for the same reasons.

9.3. Maternity

9.3.1. A small number of respondents also highlighted the possibility that employers might discriminate against women by not investing in independent prescribing courses for women who they thought were likely to take maternity leave.

9.4. Age

9.4.1. A very small number of comments were received about age. These were equally balanced between positive and negative impacts. Some respondents thought older pharmacists would lose out from having to compete with a wider pool of pharmacist independent prescribers, while others felt it created more opportunities in the careers of younger pharmacists

9.4.2. Some patients also suggested that blurring professionals' roles could be confusing for older patients.

9.5. Disability

9.5.1. A small number of respondents suggested the proposals could have a positive impact on patients with disabilities as it would improve access to medication and prescribers.

9.5.2. Some respondents noted that trainee pharmacist independent prescribers (or applicants) with learning difficulties may need extra support or find the move to an evidence-based application process more onerous than the current system which only looked at an applicant's time in their role.

9.6. Religion

9.6.1. A very small number of responses highlighted a possible negative impact on religious belief (eg pharmacists being required to act against religious beliefs, or suggesting that other prescribing professionals offered greater assurance around confidentiality)

9.7. Other impacts

Table 12: views on other impacts

Do you think anything in the standards or proposed changes would impact – positively or negatively – on any other individuals or groups?	**N and % individuals**	**N and % organisations**	**Total**
Yes	46 (14%)	12 (20%)	58 (15%)
No	215 (63%)	39 (66%)	254 (64%)
Don't know	79 (23%)	8 (14%)	87 (22%)
Grand Total	**340**	**59**	**399**

9.7.1. Respondents identified several other areas where they thought the proposals would impact on specific groups. Again, the issue of resources was raised frequently but several respondents identified positive impacts for patients and the workloads of other professionals

9.8. Impacts on course providers: resource requirements of the standards:

9.8.1. Respondents reiterated that resource pressure on course providers resulting from more onerous requirements in the standards could result in failure to comply with standards or lowering entry criteria (which would in turn impact patient safety)

9.8.2. Some respondents suggested that, as the changes were quite significant, they should be implemented in stages- particularly the introduction of designated prescribing practitioners. Respondents also suggested that a phased evaluation would enable schools of pharmacy to adapt their MPharm programmes to improve coverage of prescribing.

9.9. Impacts on employers

9.9.1. Some respondents suggested that there would be knock-on effects as course providers passed on the increased costs of training to employers, including the NHS.

9.10. Impacts on trainee independent prescribers

9.10.1. As noted in 9.2, some respondents identified potential impacts on pharmacists self-funding their independent prescriber training.

9.10.2. Some respondents suggested that raising the comparative cost of pharmacist independent prescribers in comparison to other prescribing professionals would make them less attractive to employers.

9.11. Impacts on other professions and professionals

9.11.1. Respondents identified several potential impacts on other professions. Most, but not all, were positive and largely focussed on the likely positive impacts of increasing the supply of pharmacist independent prescribers on the workloads of other professions, especially GPs.

9.11.2. Potential negative impacts included:

- pharmacist independent prescribers blurring or diluting the roles of other professionals
- reduced opportunities available to other professionals, including non-prescribing pharmacists
- that being a designated medical practitioner may be less attractive to doctors in future
- the potential for conflict between prescribers, for example, over clinical issues, or if the trainee prescriber was paid more than their designated prescribing practitioner

9.12. Impact on community pharmacy

9.12.1. As well as noting potential impacts on community pharmacy resulting from the entry requirements (see 7.8), several respondents told us that opportunities for independent prescribers were relatively limited in community pharmacy. Many respondents commented that the GPhC had a role in addressing this issue. Respondents supported their view by noting the likely benefits to patients of increasing access to pharmacist independent prescribers in the community. A few organisational respondents suggested the GPhC could do so by enabling the 'Alberta model'[4] of prescribing in community pharmacy.

9.13. Impacts on patients and the public

9.13.1. Most respondents, including patients we spoke to, were positive around the principle of pharmacist independent prescribers. Many thought it would improve access to healthcare by making prescribers easier to access for patients. Several organisations agreed, stating that the proposals would increase the supply of, and access to, treatment, helping to improve public health.

9.13.2. Several respondents suggested that the changes, particularly designated prescribing practitioners, were evaluated after a period of time (suggested to be two years). This would make sure supervision was appropriate and that the pharmacist independent prescribers they trained were safe.

9.13.3. While most respondents were positive about the proposals, several respondents to the consultation said the proposals would risk patient safety. The rationale for this view was almost entirely related to:

- belief that removing the two-year requirement for entry to an independent prescribing course would allow inexperienced pharmacists to become prescribers
- belief that non-medical independent prescribers did not have sufficient expertise or experience to act safely as supervisors

[4] The Alberta model provides for pharmacists to adapt prescriptions, prescribe in an emergency and, on successful completion of an application process, to prescribe independently, with some conditions about their knowledge and communication to other members of the patient's healthcare team. Benefits claimed for the model relate to optimising medication and improving adherence and improving accessibility of care.

9.13.4. Other suggestions made or issues raised by patients included:

- providing supervision and mentorship for newly qualified pharmacist independent prescribers
- whether/how a pharmacist independent prescriber would be able to access their records to prescribe for them
- how they would know they could access treatment from a pharmacist independent prescriber
- a desire for continuity of care

10. Respondent profile: who we heard from

A series of introductory questions sought information on individuals' general location, and in what capacity they were responding to the survey. For pharmacy professionals, further questions were asked to identify whether they were pharmacists, pharmacy technicians or pharmacy owners, and in what setting they usually worked. For organisational respondents, there was a question about the type of organisation that they worked for. The tables below present the breakdown of their responses.

10.1. Category of respondents

Table 13: individual and organisational responses

Are you responding:	**N**	% of total
As an individual	340	85
On behalf of an organisation	59	15
Total N of responses	**399**	**100%**

10.2. Profile of individual respondents

Table 14: individual respondents – breakdown by country

Where do you live?	**N**	**% of total of individual**
England	293	86%
Scotland	28	8%
Wales	14	4%
Other	5	1%
Total N of responses	**340**	**100.00%**

10.3. Profile of individual respondents

Table 15: individual respondents – breakdown individual profile

Are you responding as:	**N**	**% of total**
A member of the public	2	1%
A pharmacy professional	330	97%
A pre-registration trainee	1	0%
A student	0	0%
Other	7	2%
Total N of responses	**340**	**100%**

10.4. Profile of pharmacy professionals

Table 16: breakdown of individual pharmacy professional respondents

Are you:	**N**	**% of total pharmacy professionals**
A pharmacist	330	100%
A pharmacy technician	0	0%
A pharmacy owner	0	0%
Total N of responses	**330**	**100%**

10.5. Pharmacy professionals: areas of work

Table 17: breakdown of individual pharmacy professional respondents' area of work

Please choose the option below which best describes the area you mainly work in:	**N**	**% of total pharmacy professionals**
Community pharmacy	119	36%
Hospital pharmacy	81	25%
Primary care organisation	79	24%
Pharmacy education and training	23	7%
Pharmaceutical industry	4	1%
other	24	7%
Total N of responses	**330**	**100%**

10.6. Profile of organisational respondents

11. Table 18: type of pharmacy organisation

Is your organisation a:	**N**	**% of total organisations**
Pharmacy organisation	38	64%
Non-pharmacy organisation	21	36%
Total N of responses	**59**	**100%**

12. breakdown of type of organisational respondent

Please choose the option below which best describes your organisation:	**N**	**% of total**
Organisations representing pharmacy professionals or the pharmacy sector	13	22%
Organisation representing patients or the public	1	2%
Organisation representing a trade or industry	0	0%
Independent pharmacy (1-5 pharmacies)	0	0%
Multiple pharmacy (6 or more pharmacies)	5	8%
NHS organisation or group	14	24%

Research, education or training organisation	21	36%
Regulatory body	1	2%
Other	4	7%
Total N of responses	**59**	**100%**

13. Monitoring questions

- Data was collected on respondents' protected characteristics, as defined within the Equality Act 2010. The GPhC's equalities monitoring form was used to collect this information, using categories that are aligned with the census, or other good practice (for example on the monitoring of sexual orientation). The monitoring questions were not linked to the consultation questions and were asked to help understand the profile of respondents to the consultation, to provide assurance that a broad cross section of the population had been included in the consultation exercise. A separate equality impact assessment (EIA) has been carried out and will be published alongside the revised standards.

Appendix 1: Organisations

The following organisations engaged in the consultation through the online survey, email responses and one-to-one meetings:

- Rowlands Pharmacy
- Community Pharmacy Scotland
- BPL Ltd
- Medicines Use & Safety, NHS Specialist Pharmacy Service
- Numark Ltd
- North West Non Medical Prescribing Education Group
- University of Suffolk
- Liverpool Heart and chest Hospital NHS Foundation trust
- University of Salford
- Pharmaceutical Services Negotiating Committee
- NMC
- Northumbria Healthcare NHS Foundation Trust Pharmacy Department
- Daleacre Healthcare Limited
- University of Hull
- Academic Alliance for Healthcare Education and Professional Development
- Keele University
- Aston University
- Medicines Management Team West, Betsi Cadwaladr University Health Board
- The University of Manchester
- Healthwatch Dudley
- NHS Highland
- Wales Centre for Pharmacy Professional Education
- University of Birmingham
- NHS Lothian
- University of Reading
- Swansea University
- University of Strathclyde

Addition post Council meeting: The Royal College of General Practitioners (RCGP), Community Pharmacy Wales and Health Education England also provided responses.

- Community Pharmacy Sheffield
- Pharmacy Schools Council
- University of Leeds
- Sheffield Hallam University
- Pharmacy Forum NI
- NHS Tayside Pharmaceutical Committee
- NHS Education for Scotland
- Healthcare Improvement Scotland
- University of Bradford, School of Pharmacy and Medical Sciences
- NHS Grampian
- Medway School of Pharmacy
- De Montfort University
- Neonatal and Paediatric Pharmacists Group (NPPG)
- Liverpool John Moores University
- Association of Teaching Hospital Pharmacists (ATHP)
- Guild of Healthcare Pharmacists
- Area Pharmaceutical Committee, NHS Grampian Board
- Guild of Healthcare Pharmacists (GHP) Northern Ireland (NI) group
- Royal College of Nursing
- Medicines Management and Pharmacy Service, Leeds Teaching Hospitals
- Cardiff University
- Royal Pharmaceutical Society
- South West London and St George's NHS Trust
- Association of Prescribing
- Company Chemist' Association (CAA)
- Celesio UK
- National Pharmacy Association (NPA)
- Pharmacists' Defence Association (PDA)
- ESBT VTS Pilot Programme Project Board
- Addaction

Appendix 2: Consultation questions

Section 1: Learning outcomes

- Q1: Considering the full set of learning outcomes in Part 1 of these draft education and training standards, to what extent do you agree that these are appropriate learning outcomes for a pharmacist independent prescriber in training?
- Q2: Is there anything missing from the learning outcomes in Part 1?
- Q2a: In which of the following areas do you think there is something missing? (Please tick all that apply)
- Q2b: Please give a brief description of the gap or gaps you have identified
- Q3: Is there anything in the learning outcomes in Part 1 that should be changed?
- Q3a: Please give details of the learning outcomes you would change and why (if possible, please give the reference number of the learning outcomes)
- Q4: Please give any other feedback explaining your responses to the questions on the learning outcomes (Important: Please give both positive and negative feedback where applicable)

Section 2: Standards for course providers

- Q5: Considering the full set of standards and criteria in Part 2, to what extent do you agree that these are appropriate standards for a pharmacist independent prescribing course?
- Q6: Is there anything missing from the standards or criteria in Part 2?
- Q6a: In which of the following areas do you think there is something missing? (Please tick all that apply)
- Q6b: Please give a brief description of the gap or gaps you have identified.
- Q7: Is there anything in the standards or criteria in Part 2 that should be changed?
- Q7a: Please give details of the standards or criteria you would change and why (if possible, please give the standard or criteria reference numbers).
- Q8: Please give any other feedback explaining your responses to the questions on the standards and criteria (Important: Please give both positive and negative feedback where applicable)

Section 3: Supervising pharmacist independent prescribers in training

- Q9a: Will Domain 9 ensure that only appropriately trained and experienced independent prescribers will be acting as designated supervisors for the learning in practice part of pharmacist independent prescribing programmes?

- Q9b: Please explain your response

Section 4: Entry conditions for training

- Q10a: Should the current two-year time requirement for training be removed and replaced with a requirement for the suitability and relevance of an applicant's experience to be submitted and approved as part of the application process?

- Q10b: Please explain your response

Section 5: Impact of the standards

- Q11: Do you think anything in the standards or proposed changes would impact – positively or negatively – on certain individuals or groups who share any of the protected characteristics listed above?

- Q11a Please describe the impact and the individuals or groups concerned

- Q12: Do you think anything in the standards or proposed changes would impact – positively or negatively – on any other individuals or groups?

- Q12a: Please describe the impact and the other individuals or groups concerned

Section 6: Other comments

- Q13: Are there any other comments you would like to make about these standards or the changes we are proposing?