General Pharmaceutical Council

# Consultation on quality assurance of pharmacy education and training: analysis report

December 2024

# Contents

# Executive summary

## Background

The Pharmacy Order 2010 describes General Pharmaceutical Council's (GPhC) regulatory role in setting standards for the education and training of pharmacists and pharmacy technicians in Great Britain, and in approving their qualifications and training. Over time, the way that pharmacy education and training is quality assured has evolved, taking account of best practice in quality assurance and of how our standards have changed. However, over the last few years, there have been some significant changes in pharmacy education and training which affect its structure and what is expected from it.

The GPhC wants to make sure that the way in which quality assurance is understood and applied to pharmacy education and training remains up to date and fit for purpose. Therefore, it carried out a review of the quality assurance process and produced a set of proposals which support the Professional Standards Agency's 'Standards of Good Regulation' and GPhC's strategic aims to achieve a more tailored and intelligence-led approach to quality assurance by 2025. First, by driving improvements in pharmacy care by modernising how education and training are regulated, and also by shifting the balance towards more anticipatory, proportionate and tailored approaches to regulating pharmacy.

Between 4th April 2024 and 21 June 2024, the GPhC held a full, formal public consultation on these proposals. The consultation included an online survey, four engagement events, a focus group with patients and the public, a focus group with students and trainees, a focus group with pre-registration trainee pharmacy technicians and a webinar open to all stakeholders. The consultation was also promoted through a press release to the pharmacy trade media and via our social media. This report provides a summary of the responses to the consultation on the draft standards.

The GPhC proposed changes in quality assurance in pharmacy education and training and the consultation focused on four specific areas.

- The introduction of yearly monitoring with a greater use of data collected before approval events.
- Defining clear lines of responsibility and criteria for making decisions about whether to reapprove.
- Adopting a more flexible approval and intervention process.
- Achieving greater scrutiny of education and training, while applying GPhC quality assurance processes across all pharmacy education and training.

The online survey also explored the impact of the proposed changes on people sharing protected characteristics and those in specific groups.

There were 167 responses to the online survey (including emailed responses): 122 from individuals and 45 from organisations. 97 people attended the engagements events. A list of the organisations that responded to the consultation can be found in **Appendix 5**.

## Key issues raised in responses

### General view

Overall, there was strong support for the proposals across the four areas of change, with on average 73% of respondents to the online survey agreeing with the suggested changes. However, the comments left by respondents did not always reflect the overall level of support, tending to focus on issues and potential improvements. Two-thirds of the top ranked themes raised concerns or queries.

A perceived lack of clarity in the proposals was a top theme in all four areas, as was a concern that the proposals would bring an increased burden on providers and employers. Other themes related to the proposed timings and limitations and concerns with proposed data sources including gaps or missing data.

On a positive note, comments on the improved scrutiny and oversight which the proposals would bring was one of the top themes in three areas. Other prominent themes were the more efficient, effective and robust process that would result from the suggested changes and a general support for the proposals with the perception among those respondents that the proposals would have an overall beneficial impact.

The most prevalent response to the online survey was that overall, there would be no impact on people sharing protected characteristics - *age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation* (ranging from 38% to 53%). Overall respondents felt there would be a positive impact on other specific groups – *employers, pharmacy staff, patients and the public, students and trainees* (ranging from 35% to 45%). For education and training providers and partners however, most respondents felt the changes would bring both positive and negative impacts (44%).

### Views on yearly monitoring

A majority (70%) of respondents felt the GPhC should introduce yearly monitoring to help bridge the present gaps between interim and reapproval events. Far fewer respondents overall (19%) did not think that the GPhC should introduce yearly monitoring.

Around two-thirds (68%) of all respondents thought the seven proposed areas should be considered in the yearly monitoring of providers of all education and training - *Management, oversight and delivery of education and training, Changes affecting education and training, Experiential and inter-professional learning, Stakeholder feedback, Internal and external quality assurance, Student and trainee admissions and performance, GPhC registration assessment performance*. Around a fifth of all respondents (18%) did not think the proposed areas should be considered as part of yearly monitoring.

Of the sets of data the GPhC proposed using to strengthen the quality assurance of education and training, the use of student and trainee feedback collected by the GPhC had 75% agreement and 19% disagreement, with a higher proportion of organisations disagreeing (28%). National Student Surveys (NSS), Post Graduate Taught (PGT) surveys and equivalent subject-level data had 57% agreement, 23% disagreement, with some disparity between individuals (18%) and organisations (38%). GPhC registration assessment performance data had 74% agreement and 13% disagreement among respondents. The use of oriel assessment performance data had 63% agreement and 13% disagreement. Finally, the use of other data (for example, upheld education concerns) had 69% of respondents agreeing and 13% of all respondents disagreeing.

Around three-fifths (62%) of all respondents thought that the proposed yearly monitoring process would provide sufficient quality assurance between interim and reapproval events. However, fewer organisations (51%) shared this view compared to individuals (66%). A fifth of all respondents (20%) did not think the yearly proposed monitoring would be sufficient.

Around three-quarters of all respondents left explanatory comments on the proposal in this section. The top positive theme which emerged from these comments was the suggestion that the proposals offered improved scrutiny and oversight such as highlighting how the proposals helped to identify gaps and give the GPhC a rounded, complete and informed picture. However, the remaining top themes identified areas of concern. This included: the limitations and concerns over proposed data sources such as a view among respondents that the data sources outlined were potentially inaccurate, inconsistent, unreliable and subject to bias and could lead to misleading conclusions, the possible increased burden on providers and employers who were facing unprecedented demand and were already "overstretched", data which could be utilised but was missing from the proposals, issues related to the proposed timings of QA such as the interventions would be too frequent, a lack of flexibility and that there was no alignment with existing provider structures, the lack of clarity in the proposal was also identified here and finally a perceived lack of evidence to support the proposals.

## Views on intervention, escalation and decision-making

The proposals suggested a range of interventions to strengthen the quality assurance of education and training. When responses were analysed 77% of respondents felt that asking the provider for more evidence and information would strengthen the quality assurance of education and training, with just over one-tenth (11%) disagreeing. 73% agreed with helping the provider with a quality management activity, 12% disagreed. 86% agreed with having a focused meeting with the provider. Finally, carrying out a focused activity with the provider had 71% overall agreement with 27% disagreeing. However, there was a marked discrepancy between individuals and organisations, with over three-quarters of individuals agreeing (76%) and closer to only half of organisations having the same view (56%).

Just over three-fifths of respondents left explanatory comments in this section. The top positive themes were general support with respondents suggesting the proposals were reasonable and covered all viable options, and a view that the proposals would provide a more efficient, effective and robust process. Respondents felt overall that the proposals would make for a better intervention. The main areas of concern raised in these comments were again a lack of clarity, general negative comments or general disapproval, disapproval of the GPhC role in quality assurance including the approval team role, composition or expertise and the increased burden on providers and employers.

## Views on increased flexibility for approval and intervention

In this section 79% of respondents agreed with a flexible approach to the timing of interim and reapproval events, so that these will not be limited to taking place once every three or six years, with just over one-tenth (11%) disagreeing. 74% agreed with taking a variable approach to the periods of approval, meaning that approval status would not have a set end date but would depend on the outcome of the next planned interim and reapproval events, with 12% disagreeing. 81% agreed that QA intervention activity should be carried out as a result of an unsatisfactory yearly monitoring outcome, with 13% disagreeing. 80% agreed that a QA event (interim, exceptional interim, or reapproval) should be held as a result of an unsatisfactory QA, with 11% disagreeing.

Just under three-fifths of respondents left explanatory comments in this section. The top positive themes were that the proposals would offer a more efficient, effective and robust process, general

support and that changes would improve scrutiny and oversight. Alternatively, there were concerns related to the proposed timings of QA, a lack of clarity, an increased burden on providers and employers and an opinion among some respondents that the suggested changes would create uncertainty, decrease moral and have a negative impact on wellbeing. Of those who felt that way highlighted how the proposed changes might create both pressure and stress.

### Views on applying our processes across all pharmacy education and training

87% of respondents agreed with the proposal to apply our QA processes so that arrangements that apply to national awarding organisations also apply to private providers of pharmacy technician and support staff courses, with just one-tenth (10%) disagreeing.

81% agreed with the proposal to apply our QA processes so that arrangements that apply to MPharm providers also apply to providers of independent prescribing programmes, with just one-tenth (10%) disagreeing.

Just under three-fifths of respondents left explanatory comments in this section of the proposal. The top supportive themes found in this section were that the proposals would ensure consistency in QA process, with both the QA process itself and how the proposals aided consistency in education and training. The other popular positive theme was again that changes would improve scrutiny and oversight. The most mentioned areas of concern was an observation that the standardised approach in certain contexts was not appropriate and on occasion not possible. That there would be increased burden on providers and employers and finally that there was again lack of clarity in this section of the proposals.

## Impact of the proposed changes

### Views on impact on people sharing protected characteristics

With reference to the impact of the proposed changes on people sharing protected characteristics under the Equality Act 2010, ‘no impact’, was the most common response for all protected characteristics (38% to 53%). This was followed by ‘positive impact’ 17% and 26% and ‘don’t know’ (18% and 25%).

### Views on impact on other individuals or groups

With reference to the impact of the proposed standards on other groups, ‘positive impact’ was the most common response with patients and the public highest (62%); followed by students and trainees (56%); pharmacy staff (41%); employers (35%) and finally education and training providers (29%). For this latter group, more respondents felt the proposals would bring a combination of positive and negative impact (44%).

### Views on the impact of the proposals

The comments section on the impact of the proposals encompassed both the views on the impact on people sharing protected characteristics and views on the impact on other individuals or groups. Just over half of respondents left a comment relating to this section. The top positive themes were a range of general support for the proposals and a view among respondents that the suggested changes would improve the student experience and the provision of education and training. An additional positive theme raised in the consultation was that the changes would be in the best interest of patients, improving quality and patient safety including standards, outcomes, and patient specific benefits. The

top areas of concerns raised were that the proposals would increase the burden on providers and employers and that there was a lack of clarity. Finally, some respondents stated that the proposals would have no impact on those with protected characteristics or on the specific groups described.

## Additional themes and suggestions

In addition to the themes outlined above there were a range of other themes raised in the consultation, some of which came up across multiple sections. This is a summary of the additional themes which were raised during the consultation but were not the most common in any one section. Respondents stated that the proposed changes:

- would create a proportionate and limited process which reduced provider burden.
- were adapting to current and future changes in pharmacy.
- would create a process which used data well.
- would provide assurance to the public, patients and GPhC stakeholders.
- improved support for providers and stakeholders.
- would have a positive impact on those with protected characteristics, particularly students.
- would create a less efficient process or duplicate existing processes.
- did not engage sufficiently with certain groups.
- would have a negative impact on students.
- would have a negative impact on specific groups.
- were not interventionist enough.
- did not address inconsistencies in provision.

We also received a wide range of suggestions on alternative or additional aspects of quality assurance of pharmacy education and training. Whilst these could not be grouped thematically due to the variety and range of ideas, all comments were collated and passed on to the education team for further review.

# Introduction

## Policy background

The Pharmacy Order 2010 describes General Pharmaceutical Council's (GPhC) regulatory role in setting standards for the education and training of pharmacists and pharmacy technicians in Great Britain, and in approving their qualifications and training. The aim of this is to assure the GPhC that:

- pharmacy education and training takes place safely for everyone involved
- patients and the public can have confidence that pharmacists and pharmacy technicians joining the register are skilled and knowledgeable, and that they demonstrate appropriate professional behaviours as a result of their education and training, and
- pharmacy education and training is carried out in a way that is fair, and provides a positive experience for students and trainees

The GPhC approves pharmacy education and training provisions that have been quality assured using appropriate approval processes and which have met relevant standards in full.

Currently, the main way in which the GPhC quality assures pharmacy education and training is through regular 'approval events'. The GPhC appoints an Approval team from the Accreditation and Recognition panel to review documentary evidence, and a submission from the provider. This is done every three years for any particular provider.

Over the last few years, there have been some significant changes in pharmacy education and training which affect its structure and what is expected from it. These changes include:

- new initial education and training standards for pharmacists (2021)
- introducing a foundation training year, which will be accredited by the GPhC, to replace pharmacist pre-registration training (2025)
- new education and training standards for pharmacist independent prescribers (2022)
- new initial education and training standards for pharmacy technicians (2017), and
- new education and training requirements for pharmacy support staff (2020)

Over time, the way that pharmacy education and training is quality assured has improved, taking account of best practice in quality assurance and of how our standards have evolved. For example, since 2011, the tone of the approval events and the way the GPhC works with providers during these has improved. This means that providers are clearer about what the GPhC expects from them and how events will be carried out. The way the GPhC works with providers to get their approval submission has also been reviewed. For example:

- Ahead of an approval event, the GPhC will tell the provider which learning outcomes are going to be reviewed.
- The GPhC has produced submission templates for events, so that providers don't have to give the same information more than once.

- The GPhC is collecting more data before the event, and since 2022, this includes data from independent prescribing programmes.

However, although the current way in which the GPhC quality assures pharmacy education and training bring important benefits, such as making sure there is a regular and wide-ranging scrutiny of all providers against standards and at fixed times, it also means that the regulator checks in with providers only once in every three years. During this time, issues – such as poor performance in the registration assessment – may crop up and reach a stage where they can pose a serious concern under the standards, potentially compromising the quality of the education and training that students and trainees receive. These processes have limited GPhC's ability to spot or anticipate concerns early, or to review providers early as a result of concerns where identified.

The GPhC wants to make sure that the way in which quality assurance is understood and applied to pharmacy education and training remains up to date and fit for purpose. Therefore, the GPhC carried out a review of the quality assurance processes used by other healthcare regulators and can see that there may be advantages in adopting a similar approach to other health professions. For example, the GPhC can use a wider range of data to help them carry out quality assurance and monitoring within pharmacy education and training.

This would support two of GPhC's strategic aims to achieve a more tailored and intelligence-led approach to quality assurance by 2025 through:

- driving improvements in pharmacy care by modernising how education and training are regulated, and
- shifting the balance towards more anticipatory, proportionate and tailored approaches to regulating pharmacy

This would also support the Professional Standards Agency's 'Standards of Good Regulation', more specifically Standard 9:

*The regulator has a proportionate and transparent mechanism for assuring itself that the educational providers and programmes it oversees are delivering students and trainees that meet the regulator's requirements for registration and takes action where its assurance activities identify concerns either about training or wider patient safety concerns.*

To build upon these developments while making sure that quality assurance processes are suitable for the rapidly developing education and training provided, and act quickly if there is under-performance, the GPhC proposes to:

- introduce yearly monitoring with a greater use of data collected before an approval event
- define clear lines of responsibility and criteria for making decisions about whether or not to reapprove a course or qualification
- adopt a more flexible approval and intervention process, and
- achieve greater scrutiny of education and training, while applying the same quality assurance processes across all pharmacy education and training

For further details on the proposals, see Appendix 1: Summary of proposals.

For more detail on the changes we are proposing, see **Appendix 1: Summary of our proposals**.

# Analysis of consultation responses

In this section of the report, the tables show the level of agreement/disagreement of survey respondents to our proposed changes, or the aspects respondents felt we should modify. In each column, the number of respondents ('N') and their percentage ('%') is shown. The responses of individuals and organisations are shown separately to enable any trends to be identified. The last column in each table captures the views of all survey respondents ('Total N and %').

For more information see:

- **Appendix 2: About the consultation** for details of the consultation activities and the number of responses we received.
- **Appendix 3: Our approach to analysis and reporting** for full details of the methods used.
- **Appendix 4: Respondent profile** for a breakdown of who we heard from.
- **Appendix 5: Organisations** for a list of organisations who responded.
- **Appendix 6: Consultation questions** for a full list of the questions asked in the consultation survey.

## 1. Yearly monitoring

### 1.1 Survey response tables and analysis

**Table 1:** Views on whether GPhC should introduce yearly monitoring to help bridge the present gaps between interim and reapproval events (Base: All respondents)

| Q1: To what extent do you agree or disagree that we should introduce yearly monitoring to help bridge the present gaps between interim and reapproval events? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 36 (30%) | 4 (9%) | 40 (24%) |
| **Agree** | 54 (44%) | 23 (51%) | 77 (46%) |
| **Neither agree nor disagree** | 14 (11%) | 3 (7%) | 17 (10%) |
| **Disagree** | 8 (7%) | 9 (20%) | 17 (10%) |
| **Strongly disagree** | 10 (8%) | 5 (11%) | 15 (9%) |
| **Don't know** | 0 (0%) | 1 (2%) | 1 (1%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

Overall, a majority (70%) of respondents felt the GPhC should introduce yearly monitoring to help bridge the present gaps between interim and reapproval events. Those that shared this view included more individuals (74%) than organisational respondents (60%). In contrast, table 1 shows that far fewer respondents overall (19%) did not think that the GPhC should introduce yearly monitoring. This included 15% of individual and 31% of organisational respondents. A small percentage of respondents (10%)

neither agreed nor disagreed that the GPhC should introduce yearly monitoring, of those individual and organisational respondents made up 11% and 7% respectively.

**Table 2:** Views on whether proposed areas should be considered in the yearly monitoring of providers of all education and training (Base: All respondents)

| Q2: To what extent do you agree or disagree that the proposed areas (listed on page 16 of the proposal) should be considered in the yearly monitoring of providers of all education and training? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 29 (24%) | 3 (7%) | 32 (19%) |
| **Agree** | 60 (49%) | 22 (49%) | 82 (49%) |
| **Neither agree nor disagree** | 14 (11%) | 8 (18%) | 22 (13%) |
| **Disagree** | 7 (6%) | 7 (16%) | 14 (8%) |
| **Strongly disagree** | 11 (9%) | 5 (11%) | 16 (10%) |
| **Don't know** | 1 (1%) | 0 (0%) | 1 (1%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

In response to question 2, around two-thirds (68%) of all respondents thought the seven proposed areas should be considered in the yearly monitoring of providers of all education and training - *Management, oversight and delivery of education and training, Changes affecting education and training, Experiential and inter-professional learning, Stakeholder feedback, Internal and external quality assurance, Student and trainee admissions and performance, GPhC registration assessment performance*. However, considerably fewer organisations (56%) shared this view compared to individuals (73%). As highlighted in table 2, around a fifth of all respondents (18%) did not think the proposed areas should be considered, including a higher percentage of organisations (27%) than individuals (15%). Overall, 13% of respondents neither agreed nor disagreed, 11% of individual and 18% of organisational respondents.

**Table 3:** Views on to what extent respondents agree or disagree, in each case, that the following sets of data will strengthen the quality assurance of education and training (Base: All respondents)

| Q3: To what extent do you agree or disagree, in each case, that the following sets of data will strengthen the quality assurance of education and training? | Student and trainee feedback collected by the GPhC | National Student Surveys (NSS), Post Graduate Taught (PGT) surveys and equivalent subject-level data | GPhC registration assessment performance data (pharmacist initial education and training only) | Oriel assessment performance data (pharmacist initial education and training only) | Other data (for example, upheld education concerns) |
|---|---|---|---|---|---|
| **Strongly agree** | 52 (31%) | 38 (23%) | 45 (27%) | 31 (19%) | 41 (25%) |
| **Agree** | 73 (44%) | 56 (34%) | 76 (46%) | 74 (44%) | 73 (44%) |
| **Neither agree nor disagree** | 10 (6%) | 28 (17%) | 15 (9%) | 28 (17%) | 30 (18%) |
| **Disagree** | 21 (13%) | 14 (8%) | 13 (8%) | 9 (5%) | 9 (5%) |
| **Strongly disagree** | 10 (6%) | 25 (15%) | 9 (5%) | 13 (8%) | 6 (4%) |
| **Don't know** | 1 (1%) | 6 (4%) | 9 (5%) | 12 (7%) | 8 (5%) |
| **Total N and % of responses** | **167 (100%)** | **167 (100%)** | **167 (100%)** | **167 (100%)** | **167 (100%)** |

**Table 3.1:** Views on to what extent respondents agree or disagree, in each case, that the following sets of data will strengthen the quality assurance of education and training (Base: Individuals and organisations)

| Q3: To what extent do you agree or disagree, in each case, that the following sets of data will strengthen the quality assurance of education and training? | Student and trainee feedback collected by the GPhC | | National Student Surveys (NSS), Post Graduate Taught (PGT) surveys and equivalent subject-level data | | GPhC registration assessment performance data (pharmacist initial education and training only) | | Oriel assessment performance data (pharmacist initial education and training only) | | Other data (for example, upheld education concerns) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Individuals | Organisations | Individuals | Organisations | Individuals | Organisations | Individuals | Organisations | Individuals | Organisations |
| **Strongly agree** | 45 (37%) | 7 (16%) | 32 (26%) | 6 (13%) | 39 (32%) | 6 (13%) | 28 (23%) | 3 (7%) | 36 (30%) | 5 (11%) |
| **Agree** | 48 (39%) | 25 (56%) | 42 (34%) | 14 (31%) | 51 (42%) | 25 (56%) | 50 (41%) | 24 (53%) | 54 (44%) | 19 (42%) |
| **Neither agree nor disagree** | 10 (8%) | 0 (0%) | 22 (18%) | 6 (13%) | 9 (7%) | 6 (13%) | 17 (14%) | 11 (24%) | 15 (12%) | 15 (33%) |
| **Disagree** | 10 (8%) | 11 (24%) | 9 (7%) | 5 (11%) | 11 (9%) | 2 (4%) | 9 (7%) | 0 (0%) | 8 (7%) | 1 (2%) |
| **Strongly disagree** | 8 (7%) | 2 (4%) | 13 (11%) | 12 (27%) | 5 (4%) | 4 (9%) | 9 (7%) | 4 (9%) | 5 (4%) | 1 (2%) |
| **Don't know** | 1 (1%) | 0 (0%) | 4 (3%) | 2 (4%) | 7 (6%) | 2 (4%) | 9 (7%) | 3 (7%) | 4 (3%) | 4 (9%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** |

In response to question 3, exactly three quarters of respondents (75%) felt the use of student and trainee feedback collected by the GPhC would strengthen the quality assurance of education and training. This result was uniform across both individuals (76%) and organisations (72%). Overall, nearly a fifth of respondents (19%) disagreed, with a higher proportion of organisations disagreeing (28%), compared with only 15% of individuals. The percentage of overall respondents who neither agreed nor disagreed was low (6%), with 8% of individuals and 0% of organisations responding this way.

On whether National Student Surveys (NSS), Post Graduate Taught (PGT) surveys and equivalent subject-level data would strengthen the quality assurance of education and training, 57% of respondents overall agreed that it would. 60% of individuals and 44% of organisations shared this view. The disparity between individuals and organisations was also reflected in those respondents who

disagreed. There was 23% disagreement overall, with only 18% of individuals disagreeing rising to 38% among organisations. Overall, 17% of respondents neither agreed nor disagreed, 18% of individuals and 13% of organisations.

Once again almost three-quarters (73%) of respondents believed GPhC registration assessment performance data would strengthen the quality assurance of pharmacist education and training, with 74% of individuals and 69% organisations responding similarly. Overall, 13% of respondents disagreed, which was mirrored exactly with 13% of individuals and 13% of organisations disagreeing too. Overall, 9% of respondents neither agreed nor disagreed, 7% of individuals and 13% of organisations. While 5% of respondents overall answered don't know, with 6% of individuals and 4% of organisations.

There was a broadly uniform view among respondents that the use of oriel assessment performance data would strengthen the quality assurance of pharmacist education and training with about three-fifths of all respondents (63%), individuals (64%) and organisations (60%) agreeing. Of respondents who had other opinions, 13% of all respondents disagreed, with 14% of individuals and only 9% of organisations disagreeing. 17% of respondents overall neither agreed nor disagreed, which included 14% of individuals but a considerably higher proportion of organisations (24%).

Finally for question 3 on whether other data (for example, upheld education concerns) would strengthen the quality assurance of education and training opinion there was slightly less agreement between individuals and organisations. Although 69% of respondents overall agreed, while nearly three-quarters of individuals (74%) agreed, only about half (53%) of organisations held a similar view. However, this did not translate into a large percent of respondents disagreeing. Overall, only 9% of respondents disagreed, 11% of individuals and 4% of organisations. Instead, the relatively low level of agreement among organisations (when compared with other suggested sources of data) reflected a relatively high percentage of organisations neither agreeing nor disagreeing (33%), with 12% of individuals having a similar opinion.

**Table 4:** Views on whether the proposed yearly monitoring process will provide sufficient quality assurance between interim and reapproval events (Base: All respondents)

| Q4: To what extent do you agree or disagree that the proposed yearly monitoring process will provide sufficient quality assurance between interim and reapproval events? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 20 (16%) | 2 (4%) | 22 (13%) |
| **Agree** | 61 (50%) | 21 (47%) | 82 (49%) |
| **Neither agree nor disagree** | 13 (11%) | 11 (24%) | 24 (14%) |
| **Disagree** | 13 (11%) | 6 (13%) | 19 (11%) |
| **Strongly disagree** | 11 (9%) | 4 (9%) | 15 (9%) |
| **Don't know** | 4 (3%) | 1 (2%) | 5 (3%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

In response to question 4, around three-fifths (62%) of all respondents thought that the proposed yearly monitoring process would provide sufficient quality assurance between interim and reapproval events. However, considerably fewer organisations (51%) shared this view compared to individuals (66%). As highlighted in table 4, a fifth of all respondents (20%) did not think the yearly proposed monitoring would be sufficient, including exactly the same percentage of individual (20%) but a slightly higher percentage of organisations (22%). Overall, 14% of respondents and 11% of individuals neither agreed nor disagreed, with 24% of organisational respondents responding similarly.

## 1.2 Summary of themes

**Around three-quarters of all respondents left explanatory comments. Set out below is an analysis of the themes found in their responses.**

Respondents who left open-ended comments on this section held a range of views on yearly monitoring. However, of the top seven most popular themes that emerged six highlighted areas which respondents felt were areas of concern. Those who spoke positively about this section of the proposals felt that the changes to monitoring would offer better scrutiny and oversight.

However, issues related to time were also highlighted including that the proposals could mean monitoring would happen too often, did not encompass possible longer-term changes and improvements, did not take into account wider alignment with providers and were overall limited.

The most popular theme highlighted by respondents were limitations and concerns with proposed data sources, with another popular theme being data which could be utilised but was missing from the proposals. While the increased burden of providers and employers was also a prevalent theme.

Finally, there were two additional themes which were prevalent for organisations highlighting what they felt was a lack of clarity and overall lack of evidence to support the proposals.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- Limitations and concerns with proposed data sources
- Improved scrutiny and oversight
- Increased burden on providers and employers
- Missing data
- Concerns regarding the proposed timings of QA
- Lack of clarity or more information needed
- Lack of evidence to support proposals

## 1.3 Limitations and concerns with proposed data sources

When asked to give their views on yearly monitoring, the most common aspect that respondents felt needed further attention were the proposed sources of data. Respondents highlighted a range of limitations and concerns with the data sources outlined in the proposals.

Respondents felt the data outlined in the proposals lacked quality in that the data sources were inaccurate, inconsistent, unreliable and subject to bias and would lead to misleading conclusions. They also highlighted that certain sources were incompatible due to lack of standardisation and format variations. Respondents were also concerned about the accessibility of the data, with restricted access due to privacy, proprietary issues, or unawareness and unforeseen ethical considerations such as privacy and consent issues.

Those who had issue with the proposed data focused on how they believed various data sources were unsuitable. Some respondents in this category felt that the proposed data was in general unreliable with student feedback and provider action plans as examples of data which would not provide evidence of good or bad outcomes.

Some respondents felt there needed to be further consideration of data that explained what, why, when and how things happen. They also felt the data used lacked outcome focus, that it was unclear whether the data sets proposed would provide sufficient quality assurance, was subject to time lag, not reproduceable and that there was a risk of overreliance on data alone. Finally, some thought that there was an over reliance on certain data, for example, that there was too much focus on the registration assessment and university-based monitoring.

Some respondents went further and questioned the suitability of data due to its specificity and suggested that using data from specific sources in different settings was not appropriate. Due to its complexity, interprofessional education (IPE) and experiential learning fit into this category, with further difficulties in quantifying and standardising data from this source.

Respondents also highlighted the lack of influence education and training providers have over Oriel results. It was felt that national, standardised assessment and outcomes from Oriel assess suitability and capability of foundation training so would not work as a proxy for QA measures of MPharm curricula design, delivery and development. Some respondents also pointed out that Oriel was not used in Northern Ireland (NI). It was felt therefore that it would be an unsuitable method to assess quality. Oriel was also felt to have validity issues.

This criticism was also applied to the National Student Survey (NSS). Some of the most regular feedback highlighted the issues with the NSS as a source of evidence with validity and accuracy issues owing to its very poor design, lack of course level specificity and broad scope, low response rates and subjectivity, especially with the propensity of responses from unsatisfied students. These criticisms were also applied lesser extent to National Education and Training Survey (NETS), registration assessment data, Situational Judgement Test (SJT), Postgraduate taught experience survey (PTES) and Post Graduate Taught (PGT) surveys. One respondent highlighted that PGT courses for Independent Prescribing are under a year in length and non-credit bearing which means most universities do not perform PGT exit surveys. For respondents who mentioned these data source this made them unsuitable.

Finally, some respondents thought that the collection of certain data outlined in the proposal might breach data protection and suggested further communication would be needed for students to explain what information would be used for and what the implications for its use would be. Finally, some respondents suggested plans needed to be put in place to protect providers from wrongful reputational damage.

### 1.4 Improved scrutiny and oversight

The most common positive theme to emerge from respondents to this section centred on how the proposed yearly monitoring process offered better and more frequent scrutiny and oversight.

Respondents highlighted how the proposals helped to identify gaps and give the GPhC a rounded, complete and informed picture. They felt the proposals would enable better identification of changes, issues, slippages and areas of concern of providers' performance which could then be used to highlight improvements. Others thought the proposals would also be more timely, leading to earlier and more frequent identification of issues and action to be taken more quickly with similar positive outcomes.

Some respondents also felt that the better and more frequent oversight would fill gaps in existing oversight.

Finally, others pointed to regular monitoring as general good practice. They highlighted how the proposals would strengthen the quality assurance process, make the regulatory process more transparent, and make the whole process generally more proportionate, systematic, tailored, robust and less of a "tick-box exercise".

### 1.5 Increased burden on providers and employers

One of the most popular themes for both individuals and organisations was the issue of increased burden. It was felt by those respondents who mentioned this theme that education providers and employers were facing unprecedented demand and were already "overstretched" financially, and also by subsequent reductions in numbers of teaching staff and administrators. They felt that the proposals would create a lot of additional work, including administrative work, for staff who were already overburdened. It was felt the proposals would also create an extra financial burden too.

Some of those who commented on this theme also felt that yearly monitoring was unnecessary and linked burden to duplication of existing practice, including submitting the same quantity of information and evidence every year that was currently submitted every three years. The outcome of this increased burden was likely to be that the proposals would be detrimental to teaching and learning.

### 1.6 Missing data

Another common theme was that there was a range of data which could be utilised but was missing from the proposal. Of those who responded, reference was made to outdated data, missing data types or variables, an absence of data in certain areas, groups or populations, missing data of certain granularity or detail and specific methods of collecting that data which were also missing.

The types of data respondents felt was missing included data which originated from the providers included provider assessments "where many learning outcomes are met", data from Ether, an education management programme, data from the Apprenticeship End Point Assessment (EPA) and data on trainees who did not meet the learning outcomes. Others highlighted data which originated from other sources and "outside factors" such as pre-registration exam data and data on the number of pre-registration trainee pharmacy technicians in training each year and even the GPhC portfolio sign off, part of the initial pharmacist education.

In relation to data collection methods some respondents felt that the data sources identified did not include other components. A range of solutions was suggested to rectify that gap such as for the GPhC to run their own yearly survey, a greater amount of commentary to aid interpretation of the data, qualitative commentary relating to the specific issue(s) and even the use of more up to date methods such as electronic templates.

Another commented upon aspect of this theme was the gaps in groups and times where data was collected. Of those respondents who mentioned this theme some felt that newly qualified pharmacists should be surveyed on their experiences of whether their MPharm degree had actually prepared them for life as a foundation pharmacist. Respondents also felt this focus on whether qualified students were prepared was also applicable to employers who should also be asked for their feedback on student knowledge, skills and behaviours.

This focus on gaps in data also applied to a wider range of stakeholders with respondents suggesting that data should be sort from specific stakeholders such as commissioners, assessment groups, pharmacy contractor body representative bodies, pharmacy representative groups, such as Community Pharmacy Wales (CPW) and the Royal Pharmaceutical Society (RPS) with data also collected from their assessment and credentialing process. More generic suggestions included collecting data which highlighted strategic and workforce needs, such as availability, demand and capacity including clinical placement capacity in practice-based settings. Finally, some respondents also felt that data was missing about pharmacy technicians, including those who had been grandfathered in following changes to standards.

### 1.7 Concerns related to the proposed timings of Quality Assurance

Although respondents highlighted the positives of more frequent scrutiny and oversight, respondents also pointed to issues which could arise related to the proposed quality assurance (QA) cycles.

The most common criticism was that the interventions would be too frequent. Others were more nuanced suggesting that more flexibility was necessary, for example suggesting that if providers were doing well then the proposed monitoring was too often. Similarly, others felt that if a concern had been highlighted then time for further submissions to be presented should be allowed.

There was also a focus on how the proposed monitoring did not align with the existing provider timelines. It was pointed out that the proposed timelines did not align with already existing provider QA process cycles such as education and training standards, continued professional development (CPD), internal quality reporting and external examiner monitoring, with some commentators foreseeing a risk of overlapping reviews and actions. They highlighted the need to ensure there was enough time for the interventions to take place and to ensure relevant information was shared with other stakeholders.

Another criticism related to how the proposals were short-term. Respondents suggested greater account of longer-term trends was needed. It was suggested that proposals would only produce a “snapshot” and that in fact there was never just a single point of failure. While others suggested outcomes would take time to bear fruit, with change taking several years to become visible. It was felt that this was especially pertinent with programmes happening at varying times, with programmes having different lengths and each having their own “ebb and flow”.

### 1.8 Lack of clarity

Although not one of the most mentioned themes overall, one of the top themes mentioned by organisations who responded to the consultation was a perceived lack of clarity or ambiguity, and the call for more information. Two broad issues in this area were that firstly it was difficult to understand whether the proposals would achieve their objectives and secondly that possible concerns were not given in detail.

The most common issue related to data. Some respondents commented that they were hesitant to agree to the “Other data” section without a clearer understanding of what these could be. Others felt the overall approach to analysis and how data would be used was unclear. Many of the comments on this theme came from education and training providers, who were unclear how the process of annual reporting, analysis and response would be undertaken at the provider level. More granular responses asked for greater clarification on how the GPhC would collate student and trainee data each year.

Some respondents felt that they were unable to assess the impact of yearly monitoring without sight of the proposed data collection templates, with others pointing out that there was no information included

in the consultation on how the interim and reapproval documentation might change as a result of enhanced annual monitoring. Two more areas were mentioned with reference to data. Some respondents wished for a fuller explanation of the proposed decision making, intervention and escalation model. While some respondents felt the detail in the consultation document did not link the large number of data sources, collected in a variety of ways, from a number of sources, to the aims of the assessment process.

Two less mentioned areas requiring greater clarity related to time and burden. Respondents commented that the timelines for feedback from the GPhC on the annual return and any subsequent processes were not outlined. Others were unclear what the impact would be and asked for more clarity from the GPhC on potential workload, affordability, resource burden and practicalities.

### 1.9 Lack of evidence to support proposals

Another top theme mentioned by organisations but not one of the most mentioned themes overall was the proposals' lack of evidence. This tended to fall into two categories, the first was a lack of evidence on the need and rationale for change. For those with specific comments on this it was noted that there was no evidence that the current regime was not already effective, sufficient or efficient. Respondents asked for evidence of the possible shortfalls or failings of the current process, for evidence this level of monitoring was warranted for pharmacy education and also asking for evidence of the change in burden.

The second category mentioned under this theme was the lack of evidence of impact and outcomes of the proposal. Those who commented on this felt there was a lack of evidence that the proposed new methodology would produce definite benefits and no evidence that the new approach would improve the quality of newly registered pharmacists. Some also felt it was not clear what could be gained from this that is not gained from other evaluation work within programmes.

Although these were the two main subthemes under this theme there was also again comments relating to data and what the evidence for using the new data sources was. Overall, the response of respondents to the perceived lack of evidence was either to feel that there was a need for revision, that this made the proposals unjustified or that there was the need to test the proposals for example with a "limited pilot".

# 2. Intervention, escalation and decision-making

## 2.1 Survey response tables and analysis

**Table 5:** Views on whether a range of interventions will strengthen the quality assurance of education and training (Base: All respondents)

| Q6: To what extent do you agree or disagree that, in each case, the following interventions will strengthen the quality assurance of education and training? | Asking the provider for more evidence and information (for example, action plans) | Helping the provider with a quality management activity (for example, assessment standard setting) | Having a focused meeting with the provider (for example, a conversation about the concern) | Carrying out a focused activity with the provider (for example, a visit or observing teaching) |
|---|---|---|---|---|
| **Strongly agree** | 45 (27%) | 44 (26%) | 59 (35%) | 49 (29%) |
| **Agree** | 87 (52%) | 78 (47%) | 86 (51%) | 70 (42%) |
| **Neither agree nor disagree** | 16 (10%) | 23 (14%) | 9 (5%) | 17 (10%) |
| **Disagree** | 7 (4%) | 9 (5%) | 6 (4%) | 14 (8%) |
| **Strongly disagree** | 11 (7%) | 11 (7%) | 6 (4%) | 16 (10%) |
| **Don't know** | 1 (1%) | 2 (1%) | 1 (1%) | 1 (1%) |
| **Total N and % of responses** | **167 (100%)** | **167 (100%)** | **167 (100%)** | **167 (100%)** |

**Table 5.1:** Views on whether a range of interventions will strengthen the quality assurance of education and training (Base: individuals and organisations)

| Q6: To what extent do you agree or disagree that, in each case, the following interventions will strengthen the quality assurance of education and training? | Asking the provider for more evidence and information (for example, action plans) | | Helping the provider with a quality management activity (for example, assessment standard setting) | | Having a focused meeting with the provider (for example, a conversation about the concern) | | Carrying out a focused activity with the provider (for example, a visit or observing teaching) | |
|---|---|---|---|---|---|---|---|---|
| | Individuals | Organisations | Individuals | Organisations | Individuals | Organisations | Individuals | Organisations |
| **Strongly agree** | 40 (33%) | 5 (11%) | 37 (30%) | 7 (16%) | 51 (42%) | 8 (18%) | 42 (34%) | 7 (16%) |
| **Agree** | 58 (48%) | 29 (64%) | 53 (43%) | 25 (56%) | 55 (45%) | 31 (69%) | 51 (42%) | 19 (42%) |
| **Neither agree nor disagree** | 10 (8%) | 6 (13%) | 12 (10%) | 11 (24%) | 5 (4%) | 4 (9%) | 11 (9%) | 6 (13%) |
| **Disagree** | 5 (4%) | 2 (4%) | 8 (7%) | 1 (2%) | 5 (4%) | 1 (2%) | 6 (5%) | 8 (18%) |
| **Strongly disagree** | 9 (7%) | 2 (4%) | 11 (9%) | 0 (0%) | 6 (5%) | 0 (0%) | 12 (10%) | 4 (9%) |
| **Don't know** | 0 (0%) | 1 (2%) | 1 (1%) | 1 (2%) | 0 (0%) | 1 (2%) | 0 (0%) | 1 (2%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** | **122 (100%)** | **45 (100%)** |

When overall responses were analysed over three-quarters (79%) of overall respondents felt that asking the provider for more evidence and information would strengthen the quality assurance of education and training, with just over one-tenth (11%) disagreeing and a similar amount neither agreeing nor disagreeing or not knowing (10% and 1%). This was broadly reflective of the results when individuals and organisations were examined separately.

These results were similar when looking at whether helping the provider with a quality management activity would strengthen the quality assurance of education and training with just under three-quarters (73%) agreeing and just over one-tenth disagreeing (12%). When comparing individuals and organisations, there were similar levels of agreement, but a much larger proportion of individuals disagreed (16% compared with 2%) and nearly a quarter of organisations (24%) neither agreeing nor disagreeing.

The intervention which received the most support was having a focused meeting with the provider with nearly nine-tenths (86%) agreement which was reflected both with individuals and organisations. The final intervention – Carrying out a focused activity with the provider, garnered slightly less support with 71% of overall respondents suggesting this intervention would strengthen the quality assurance of education and training. However, here there was a marked discrepancy between individuals and organisations, with over three-quarters of individuals agreeing (76%), whereas closer to half of organisations agreed (58%) and over a quarter (27%) disagreeing.

**Table 6:** Views on the extent the teams allocated to each type of intervention activity are appropriate decision makers (Base: All respondents)

| Q7: To what extent do you agree or disagree that the teams allocated to each type of intervention activity are appropriate decision makers? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 22 (18%) | 3 (7%) | 25 (15%) |
| **Agree** | 50 (41%) | 18 (40%) | 68 (41%) |
| **Neither agree nor disagree** | 19 (16%) | 10 (22%) | 29 (17%) |
| **Disagree** | 10 (8%) | 4 (9%) | 14 (8%) |
| **Strongly disagree** | 13 (11%) | 3 (7%) | 16 (10%) |
| **Don't know** | 8 (7%) | 7 (16%) | 15 (9%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

Of the survey respondents who left explanatory comments just over half (56%) agreed that the teams allocated to each type of intervention activity are appropriate decision makers, with around a fifth (18%) disagreeing, 17% neither agreeing nor disagreeing and approximately one-tenth (9%) not knowing. When analysis was completed by individual and organisation separately relatively more individuals agreed (59%) compared to organisations (47%) with the percentage of organisations neither agreeing nor disagreeing (22%) and not knowing (16%) higher overall.

## 2.2 Summary of themes

**Just over three-fifths of respondents left explanatory comments in this section. Set out below is an analysis of the themes found in their responses.**

Unlike the comments on yearly monitoring the comments on intervention, escalation and decision-making were more evenly spread between the positive and negative, with two of the top six being positive. Those who spoke positively about this section of the proposals offered a more generalised support and felt the process was more efficient, effective and robust. However, there were a range of negative comments about this section of the proposals, with lack of clarity and increased burden once again often being mentioned, and respondents also disagreeing with the accreditation team composition or expertise.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- Lack of clarity
- General support
- Disapproval of GPhC role in QA
- General negative comments
- Increased burden on providers and employers
- More efficient, effective and robust process

## 2.3 Lack of clarity

The top theme overall in this section was reserved for the proposals' lack of clarity. This theme has been discussed in detail in section 1.8 above, however, there were a few differences between these two sections which warrant mentioning. A high proportion of comments referenced a general lack of clarity in this section.

Comments on lack of clarity covered all aspects of this section including intervention, escalation and decision-making. Overall, respondents pointed to a lack of clarity about the teams involved, including the difference between the teams for example the reaccreditation team and a monitoring team, how they would be involved and when. Commentors were also unclear on team selection, balance, consistency and the qualifications necessary to be part of the team. They also felt more information was needed on decision making, including lines of responsibility for decision making and the link between decision making and the concerns matrix.

Respondents also spoke specifically about what they saw as a lack of detail on the interventions including what a focused activity would involve and its resource implications. They were also of the opinion that there was a lack of clarity on the type and form of support available. This included a number of respondents who felt unsure whether the interventions were indeed supportive or actually disciplinary and punitive. In relation to the intervention, escalation and decision-making process some respondents again made reference to timeliness, wanting more clarity on how the approval process would fit in with interim visits.

Finally, those who left comments on this section suggested there was a lack of detail on non-approval including thresholds, escalation and the practicalities should accreditation fail including the transfer of students.

## 2.4 General support

The most common positive response of those who made comments, was general positivity. This took the form of overall support with no specific details included in the comment. In this theme of general support, respondents agreed and were happy with the proposals and felt the proposals were reasonable and covered all viable options.

## 2.5 Disapproval of GPhC role in QA

Another common theme related to a range of concerns around the GPhC's role in quality assurance and the approval team role, composition or expertise. The highest number of comments in this section were reserved for the composition and expertise of the QA team. Commentators broadly felt that the team should include practitioners, practising pharmacists or in certain cases only practising pharmacists. It was felt that unlike "disconnected GPhC types" these practitioners were the only people with sufficient

expertise and that these were the people students would have to work with once qualified. Finally, one respondent feared that there may be bias if the approval teams were made up of "competitor" schools.

Other concerns focused on a general questioning of whether GPhC was best placed to perform the role of quality assurance with commenters querying whether the GPhC was best placed to provide help with quality management processes and activities. Others felt there were clear monitoring and quality assurance policies and processes already in place and that institutions were already able to identify appropriate sources of guidance if needed. Some respondents also felt there might be a negative impact if the role of the GPhC was blurred. They disagreed with the GPhC acting as both a quality assurer and as a training organisation for the providers being accredited.

Another sub-theme on which respondents made comments was the role, composition or expertise of the approval team. Of those who made comments on this theme there was a suggestion that the approval team must have total and full oversight of the whole accreditation process and it is they who should decide which interventions may be delegated to the GPhC QA team. Alternatively, it was suggested that the quality assurance team should always be involved and as the proposal was written the approval team could be the only ones involved.

## 2.6 General negative comments

As well as a range of general positive comments there were also a range of general negative comments. Once again, these comments took the form of a general disapproval of the proposals but with no specific details included in the comment. Under the theme of general negative comments there included a general disenchantment with GPhC highlighting its speed of response more generally and its lack of efficiency. Others felt the changes were unnecessary and a waste of time, with some also disliking the proposed action plans and focused meetings.

## 2.7 More efficient, effective and robust process

The other positive comments, although raised by a larger proportion of individuals than organisations, were by those who felt the proposed intervention, escalation and decision-making processes were more efficient, effective and robust.

These comments included the perception that the proposals would make for a better intervention which would be more effective, proficient and robust. Including that the proposals would strengthen QA providing better service provision while addressing weaknesses.

The most common comment in this section spoke about how the proposed processes would help remedy or resolve issues and concerns earlier and quicker or more promptly, with flexibility highlighted as one aspect which would help to achieve this. However, this proficiency did not only apply to issues and conflicts, with comments that the proposals would mean that any changes would be implemented quickly.

Finally, other comments mentioned that the proposals would lead to better use of resources, be more productive, tailored and fit for purpose, more timely, low impact and would enable greater capacity.

## 2.8 Increased burden on providers and employers

Although not one of the top overall themes in this section one of the top themes for organisations was again the increased burden the proposals would bring. These comments reflected those outlined in section 1.5 above, however, respondents also commented more specifically on intervention, escalation and decision-making. It was noted again that education providers and employers were facing greater

demand and less capacity. They also felt the proposals were unnecessary and linked burden to duplication of existing intervention, escalation and decision-making practice.

# 3. Increased flexibility for approval and intervention

## 3.1 Survey response tables and analysis

**Table 7:** Views on taking a flexible approach to the timing of interim and reapproval events (Base: All respondents)

| Q9: To what extent do you agree or disagree with taking a flexible approach to the timing of interim and reapproval events, meaning that these will not be limited to taking place once every three or six years? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 41 (34%) | 10 (22%) | 51 (31%) |
| **Agree** | 55 (45%) | 25 (56%) | 80 (48%) |
| **Neither agree nor disagree** | 13 (11%) | 7 (16%) | 20 (12%) |
| **Disagree** | 7 (6%) | 2 (4%) | 9 (5%) |
| **Strongly disagree** | 6 (5%) | 1 (2%) | 7 (4%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

When overall responses were analysed nearly four fifths (79%) agreed with a flexible approach to the timing of interim and reapproval events, so that these will not be limited to taking place once every three or six years, with just under one-tenth (9%) disagreeing and a slightly higher proportion neither agreeing nor disagreeing (12%). This was broadly reflective of the results when individuals and organisations were examined separately, with a slightly higher percentage of organisations neither agreeing nor disagreeing (16% compared with 11%).

**Table 8:** Views on taking a variable approach to the periods of approval (Base: All respondents)

| Q10: To what extent do you agree or disagree with taking a variable approach to the periods of approval, meaning that approval status will not have a set end date but will depend on the outcome of the next planned interim and reapproval events? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 31 (25%) | 8 (18%) | 39 (23%) |
| **Agree** | 62 (51%) | 21 (47%) | 83 (50%) |
| **Neither agree nor disagree** | 13 (11%) | 9 (20%) | 22 (13%) |
| **Disagree** | 7 (6%) | 3 (7%) | 10 (6%) |
| **Strongly disagree** | 8 (7%) | 2 (4%) | 10 (6%) |
| **Don't know** | 1 (1%) | 2 (4%) | 3 (2%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

When overall responses were analysed nearly three quarters (73%) agreed with taking a variable approach to the periods of approval, meaning that approval status would not have a set end date but would depend on the outcome of the next planned interim and reapproval events, with just over one-tenth (12%) disagreeing and slightly more neither agreeing nor disagreeing or not knowing (13% and 2% respectively). This was broadly reflective of the results of individuals, however, organisations agreed a little less (65%), with once again a higher percentage (20%) neither agreeing nor disagreeing.

**Table 9:** Views on QA intervention activity being carried out as a result of an unsatisfactory yearly monitoring outcome (Base: All respondents)

| Q11: To what extent do you agree or disagree that a QA intervention activity should be carried out as a result of an unsatisfactory yearly monitoring outcome? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 53 (43%) | 11 (24%) | 64 (38%) |
| **Agree** | 47 (39%) | 24 (53%) | 71 (43%) |
| **Neither agree nor disagree** | 6 (5%) | 5 (11%) | 11 (7%) |
| **Disagree** | 4 (3%) | 4 (9%) | 8 (5%) |
| **Strongly disagree** | 10 (8%) | 1 (2%) | 11 (7%) |
| **Don't know** | 2 (2%) | 0 (0%) | 2 (1%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

When overall responses were analysed over four fifths (81%) agreed that QA intervention activity should be carried out as a result of an unsatisfactory yearly monitoring outcome, with 12% disagreeing and less neither agreeing nor disagreeing or not knowing (7% and 1% respectively). This was broadly reflective of the results of individuals, however, organisations agreed a little less (77%), with once again a higher percentage (11%) neither agreeing nor disagreeing.

**Table 10:** Views on whether a QA event (interim, exceptional interim, or reapproval) should be held as a result of an unsatisfactory QA (Base: All respondents)

| Q12: To what extent do you agree or disagree that a QA event (interim, exceptional interim, or reapproval) should be held as a result of an unsatisfactory QA | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 48 (39%) | 9 (20%) | 57 (34%) |
| **Agree** | 52 (43%) | 25 (56%) | 77 (46%) |
| **Neither agree nor disagree** | 7 (6%) | 7 (16%) | 14 (8%) |
| **Disagree** | 4 (3%) | 3 (7%) | 7 (4%) |
| **Strongly disagree** | 10 (8%) | 1 (2%) | 11 (7%) |
| **Don't know** | 1 (1%) | 0 (0%) | 1 (1%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

When overall responses were analysed four fifths (80%) agreed that a QA event (interim, exceptional interim, or reapproval) should be held as a result of an unsatisfactory QA, with just over one tenth (11%) disagreeing and a little under one tenth neither agreeing nor disagreeing or not knowing (8% and 1% respectively). This was broadly reflective of the results of individuals, however, once again organisations had a higher percentage (16%) neither agreeing nor disagreeing.

## 3.2 Summary of themes

**Just under three-fifths of respondents left explanatory comments in this section. Set out below is an analysis of the themes found in their responses.**

Comments on increased flexibility for approval and intervention were fairly evenly spread between positive and negative themes, with three of the top seven being positive and four being negative. The comments of those who spoke positively about this section related to a more efficient, effective and robust process, general support for the proposals, and improved scrutiny and oversight. Negative comments related to concerns about proposed timings of the QA, lack of clarity and the need for more information, the increased burden that the proposals would generate and the uncertainty and negative impact on wellbeing that may result from implementation.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- More efficient, effective and robust process
- Concerns related to proposed timings of QA
- General support
- Lack of clarity
- Increased burden on providers and employers
- Uncertainty and negative impact on wellbeing
- Improved scrutiny and oversight

## 3.3 More efficient, effective and robust process.

The most common theme amongst respondents was that the proposals around increased flexibility would ultimately result in a more efficient, effective and robust quality assurance process. The comments in this section closely reflected those relating to intervention, escalation and decision-making (see section 2.8 above).

In these comments it was noted by respondents that the proposals would strengthen QA providing a better service provision while addressing weaknesses. Comments in this section commonly focused on how the proposed processes would be timelier, helping remedy or resolve issues and concerns earlier and quicker or more promptly. Flexibility was again highlighted as one aspect which would help to achieve this.

Of those that commented there was also mention of the proposals making the QA process more robust and proportional. Another comment in this theme was that the proposals would require fewer interventions meaning lower overall impact on providers and employers. Finally, it was felt that the proposals would help prevent duplication and repetition and lead to more targeted use of resources and overall better service provision.

## 3.4 Concerns related to proposed timings of QA

The most common criticism was that the interventions would be too frequent. Others were more nuanced suggesting that more flexibility was necessary, for example suggesting that if providers were doing well then monitoring was too often. Similarly, others felt that if a concern had been highlighted then time for further submissions to be presented should be allowed.

There was also a focus on how the proposed monitoring did not align with the existing provider timelines. It was pointed out that the proposed timelines did not align with already existing provider QA process cycles such as education and training standards, continued professional development (CPD), internal quality reporting and external examiner monitoring, with some commentators foreseeing a risk of overlapping reviews and actions. They highlighted the need to ensure there was enough time for the interventions to take place and to ensure relevant information was shared with other stakeholders.

Another criticism related to how the proposals were short-term. Respondents suggested greater account of longer-term trends was needed. It was suggested that proposals would only produce a "snapshot" and that in fact there was never just a single point of failure. While others suggested outcomes would take time to bear fruit, with change taking several years to become visible. It was felt that this was especially pertinent with programmes happening at varying times, with programmes having different lengths and each having their own "ebb and flow".

## 3.5 General support

Another common positive response of those who made comments, was general positivity about the proposed flexibility. Like in section 2.4 above this took the form of overall support with no specific details included in the comment. In this section, respondents felt the changes were good, important, were logical and made sense, were useful and that they had no concerns.

## 3.6 Lack of clarity

Once again, a theme which appeared in comments on this section related to the perceived lack of clarity or ambiguity in the proposals, and the call for more information. These comments predominantly highlighted a lack of clarity about interventions and quality assurance events.

This included a call for more clarity on the benefits of any intervention but also what the activities were and how they differentiated or what they "looked like". There were also comments about expectations, thresholds, the criteria for monitoring or intervention outcomes, such as changes to standards, qualifications and key staff.

For those who commented on the proposals lack of clarity on expectations they felt the proposals also included a lack of clarity on the questions and information which would be expected of the providers.

Another aspect of the lack of clarity related to timeliness, timelines and timescales. This included how long would be allowed for response, change, and the time limits for interim and full accreditation events.

Finally, of those who commented on this section there was concern about the lack of clarity on the reach of these proposals. This included whether organisations that provide experiential learning as part of the undergraduate pharmacist degrees would need to be included in the processes for quality assurance of education and training.

### 3.7 Increased burden on providers and employers

These comments very closely reflected those outlined in the above sections (see sections 1.5 and 2.7). Respondents felt the proposals would lead to increased amount of time, effort, workload, administration, implementation and cost. These respondents felt this would affect staff, providers and employers. This could lead to increasing levels of stress in groups who were already at "breaking point".

### 3.8 Uncertainty and negative impact on wellbeing

Another concern relating to the increased flexibility of approval and interventions was the concept that the proposals would create uncertainty, decrease morale and have a negative impact on wellbeing.

The majority of the comments on this theme suggested that by removing certainty and introducing a continual process of investigation would help to create pressure, lower morale and in certain circumstance "extreme" stress. It was suggested in these comments that the pressure and stress would impact a range of people. For staff yearly uncertainty and observation could negatively impact their health and wellbeing. For providers and employers there would be uncertainty over the planning of staff and resources. Wider pharmacy stakeholders and groups would be left feeling unimportant. Finally, there would be uncertainty for students who would not know what would happen if their course failed part way through.

### 3.9 Improved scrutiny and oversight

Of those who made comments on this section a positive theme revolved around the improved scrutiny and oversight which would come from these proposals. These comments broadly reflected those in the yearly monitoring section (see 1.4 above) including that early intervention would help identify any issues or concerns early and ensure students had access to the highest standards of training.

They also felt increased touch points would help providers to be kept accountable and education current, relevant, and modern. Both in its approach to readying a workforce and in support the growing demand for pharmacy services. Finally, if this increased oversight was also more in depth the proposals would allow more clarity, accurate and targeted focus and a lighter touch where necessary.

# 4. Applying our processes across all pharmacy education and training

## 4.1 Survey response tables and analysis

**Table 11:** Views on to apply QA processes so that arrangements that apply to national awarding organisations also apply to private providers of pharmacy technician and support staff courses (Base: All respondents)

| Q14: To what extent do you agree or disagree with our proposal to apply our QA processes so that arrangements that apply to national awarding organisations also apply to private providers of pharmacy technician and support staff courses? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 56 (46%) | 15 (33%) | 71 (43%) |
| **Agree** | 49 (40%) | 24 (53%) | 73 (44%) |
| **Neither agree nor disagree** | 5 (4%) | 1 (2%) | 6 (4%) |
| **Disagree** | 3 (2%) | 2 (4%) | 5 (3%) |
| **Strongly disagree** | 9 (7%) | 2 (4%) | 11 (7%) |
| **Don't know** | 0 (0%) | 1 (2%) | 1 (1%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

When overall responses were analysed nearly nine out of ten respondents (87%) agreed with the proposal to apply our QA processes so that arrangements that apply to national awarding organisations also apply to private providers of pharmacy technician and support staff courses, with just one-tenth (10%) disagreeing and the remaining neither agreeing nor disagreeing or not knowing (4% and 1% respectively). This was broadly reflective of the results when individuals and organisations were examined separately.

**Table 12:** Views on whether to apply our QA processes so that arrangements that apply to MPharm providers also apply to providers of independent prescribing programmes (Base: All respondents)

| Q15: To what extent do you agree or disagree with our proposal to apply our QA processes so that arrangements that apply to Mpharm providers also apply to providers of independent prescribing programmes? | N and % individuals | N and % organisations | N and % Total |
|---|---|---|---|
| **Strongly agree** | 51 (42%) | 13 (29%) | 64 (38%) |
| **Agree** | 50 (41%) | 22 (49%) | 72 (43%) |
| **Neither agree nor disagree** | 7 (6%) | 4 (9%) | 11 (7%) |
| **Disagree** | 4 (3%) | 1 (2%) | 5 (3%) |
| **Strongly disagree** | 9 (7%) | 2 (4%) | 11 (7%) |
| **Don't know** | 1 (1%) | 3 (7%) | 4 (2%) |
| **Total N and % of responses** | **122 (100%)** | **45 (100%)** | **167 (100%)** |

When overall responses were analysed just over four fifths (81%) agreed with the proposal that arrangements that apply to MPharm providers also apply to providers of independent prescribing programmes, with just one-tenth (10%) disagreeing and the remaining neither agreeing nor disagreeing or not knowing (7% and 2% respectively). This was broadly reflective of the results when individuals and organisations were examined separately, however a higher percentage of organisations once again neither agreed nor disagreed or did not know (9% and 7% respectively).

## 4.2 Summary of themes

**Just under three-fifths of respondents left explanatory comments in this section. Set out below is an analysis of the themes found in their responses.**

Comments on applying processes across all pharmacy education and training were again fairly evenly spread with negative themes slightly more popular than positive themes with two of the top five being positive and three being negative. The top two themes in this section, that the proposals would ensure consistency in QA process and in the provision of education and training and that a standardised approach was not appropriate, did not appear in the top themes in other sections.

The comments of those who spoke positively about this section wrote about how the proposals would ensure consistency in QA process and in the provision of education and training and improve scrutiny and oversight. Negative comments related to the inappropriateness of a standardised approach, increased burden, a lack of clarity and the need for more information.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- Ensures consistency in QA process and in the provision of education and training
- Standardised approach is not appropriate

- Improved scrutiny and oversight
- Increased burden on providers and employers
- Lack of clarity

### 4.3 Ensures consistency in QA process and in education and training

The most common theme amongst respondents was the increase in consistency that the proposals would provide. This consistency referred to both the QA process itself and how the proposals aided consistency in education and training.

For those who made comments in this section the proposals ensured consistency in the application of QA. For them the uniform approach would provide the same standard of scrutiny, with judgements made in the same way. It would also provide equity and parity or in other words a process which was fair and applied to everyone.

Aligning QA would mean pharmacists, pharmacy technicians and Independent Prescribers (IP) were comparable, leading to common themes and wider feedback, with clear roles and focus points for providers and the GPhC.

For some respondents this consistency was key to ensuring a well-rounded and highly skilled workforce. Stability in the quality and content of what is being taught would help to produce overall consistent provision and help to address variations in interprofessional learning and training including current course variability. The proposals would ensure standards of the profession are upheld to the highest level consistently, rather than simply at the single point of review. One respondent identified the drop in the quality of pharmacy technicians since COVID as a clear sign for the need for consistency.

There were a few other areas of consistency which were identified by respondents. It was felt that the proposals would help with administration, streamlining and bringing consensus across equivalent programmes, with others believing it would help unite the profession. Finally, respondents felt that the consistency that the proposals would achieve will help to ensure a safe environment, with patients and the public, government and all healthcare professionals having confidence in the competence of GPhC registrants' ability to undertake their work safely and effectively.

### 4.4 Standardised approach is not possible or appropriate

This theme represented the most common concern amongst respondents and captures the overall view that a standardised approach is either not possible or not appropriate. Respondents emphasised the need to take into account overall context and the need to provide appropriate adjustments for those different contexts. The contexts mentioned by those who made comments in this section focused on two closely linked aspects. The first was the differences between programmes.

Some of the contexts where respondents felt a standardised approach may not be appropriate were courses where most learning happened in the workplace and in which the type of pharmacy used in a placement was a factor. It was also felt standardisation was not appropriate for courses which were shorter. Here it was felt either the proposals were too generic or alternatively it was easier to make swift changes in response to issues compared to other courses.

Others identified the experience and number of the students on the course as a context which made standardisation impossible. It was pointed out that independent prescriber courses involved students who were already registered pharmacists and had already completed an accredited course so were at a somewhat higher level and lower risk of failure. Furthermore, the smaller numbers of pharmacists on IP

courses both changed the metrics of measurement and affected the amount of data and therefore its usefulness.

The differences between courses as problematic to standardisation was closely linked to the other aspect where standardisation was felt to be inappropriate or not possible. Respondents identified the framework for review and intervention was likely to be different for programmes that ran on a four or five-year cycle compared to those that are one academic year or shorter or where there were several intakes during the same academic year. It was felt that this issue of time was also likely to affect the time it took for change to become visible, with it taking longer courses more time to make changes and see the results of those changes.

### 4.5 Improved scrutiny and oversight

Of those who made comments on this section a positive theme revolved around the improved scrutiny and oversight which would come from these proposals. These comments broadly reflected those in the earlier sections (see 1.4 and 3.9) including that greater scrutiny would ensure consistent quality assurance and early intervention would help identify any issues or concerns early to ensure students had access to the highest standards of training.

Other positives improved scrutiny and oversight would provide included closing the gaps in monitoring which were currently across pharmacy education and training. A standardisation in the level of skill and knowledge expected of all roles within a pharmacy team. Ensuring the highest level of professional and clinical conduct. Helping to ensure a patient centred approach and focus. Finally, it was felt that the improvements suggested would offer pharmacy stakeholder a chance to discuss what needs to happen for positive change in the industry.

### 4.6 Increased burden on providers and employers

These comments very closely reflected those outlined in the above sections (see 1.5, 2.7 and 3.7). Once again respondents identified increased amount of time and effort in complying with the monitoring processes, increased workload and increased cost affecting staff, providers - especially small providers and employers.

### 4.7 Lack of clarity

Lack of clarity and a call for more information was again a popular theme mentioned by respondents in this section. Broadly similar aspects were mentioned as in earlier section (see 1.8, 2.3 and 3.6), such as types of data, benefits and resource implication. However, other aspects were specific to this section.

This included a lack of clarity about why these measures would necessarily apply to pharmacy technician training. Respondents queried how the proposals would take into account the costs of and capacity for data collection across the spectrum of providers, including the likely measures used for organisations outside of HEIs. There was a call for more information on the proportionality across these different education settings including with regards to data. Finally, one respondent asked for more clarity and information about risk.

# 5. The impact of the proposed changes on people sharing protected characteristics and those in specific groups

## 5.1 Survey response charts and analysis

**Figure 1:** Views of all respondents (N = 167) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

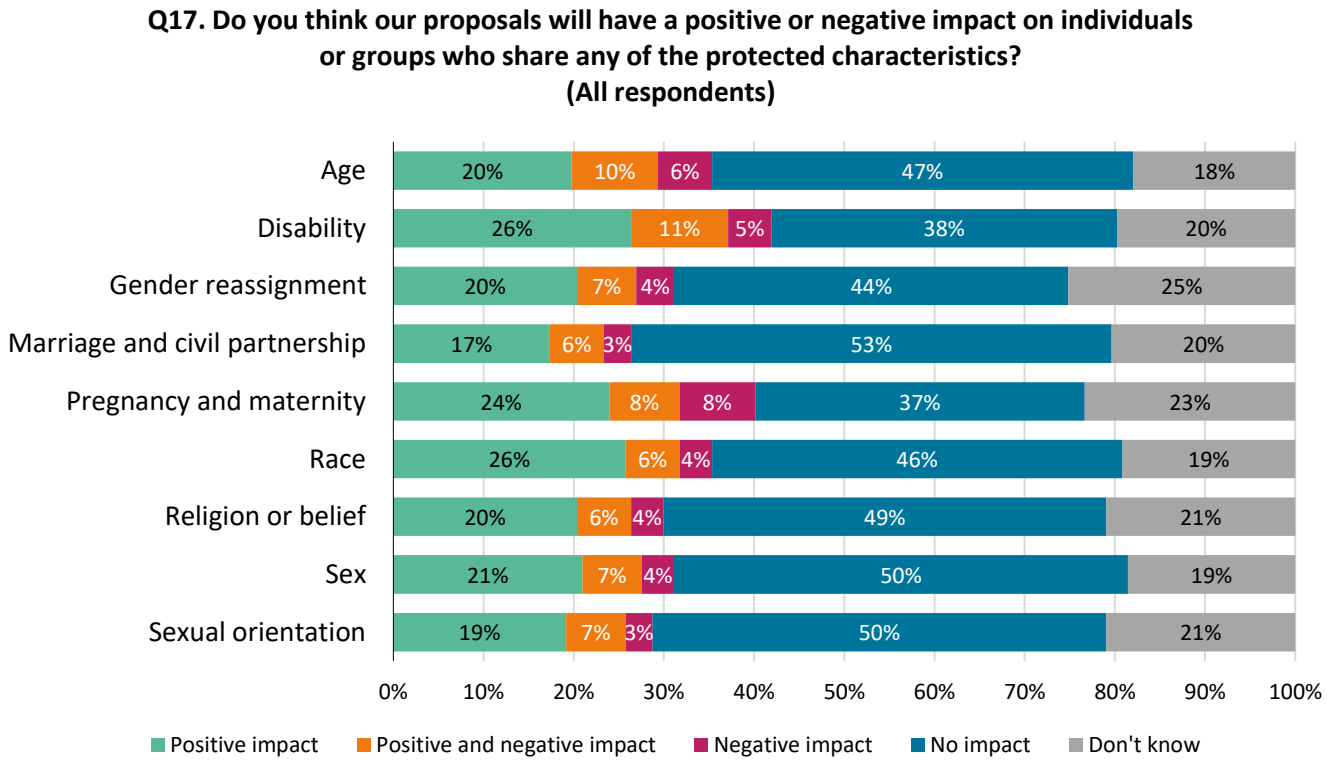


Figure 1 shows that the highest percentage of respondents (ranging from 38% to 53%) felt that our proposals would have no impact on each of the protected characteristics.

Between 17% and 26% of respondents felt there would be a positive impact on groups or individuals who share each of the nine protected characteristics. The protected characteristic on which respondents thought the proposals would have the largest positive impact was disability (26%) and race (26%). A similar proportion of respondents (between 18% and 25%) did not know what the impact of the proposals would be.

Only a small proportion of respondents (between 3% and 8%) felt that the proposals would have a negative impact on people sharing one or more of the nine protected characteristics, with pregnancy and maternity (8%) scoring the highest in this category. Slightly more respondents (ranging from 6% to 11%) indicated that the proposals would have both a positive and negative impact on each of the protected characteristics.

A full breakdown of individual and organisational responses to this question is available in **Appendix 7**.

**Figure 2:** Views of all respondents (N = 167) on whether our proposals positively or negatively impact any other individuals or groups

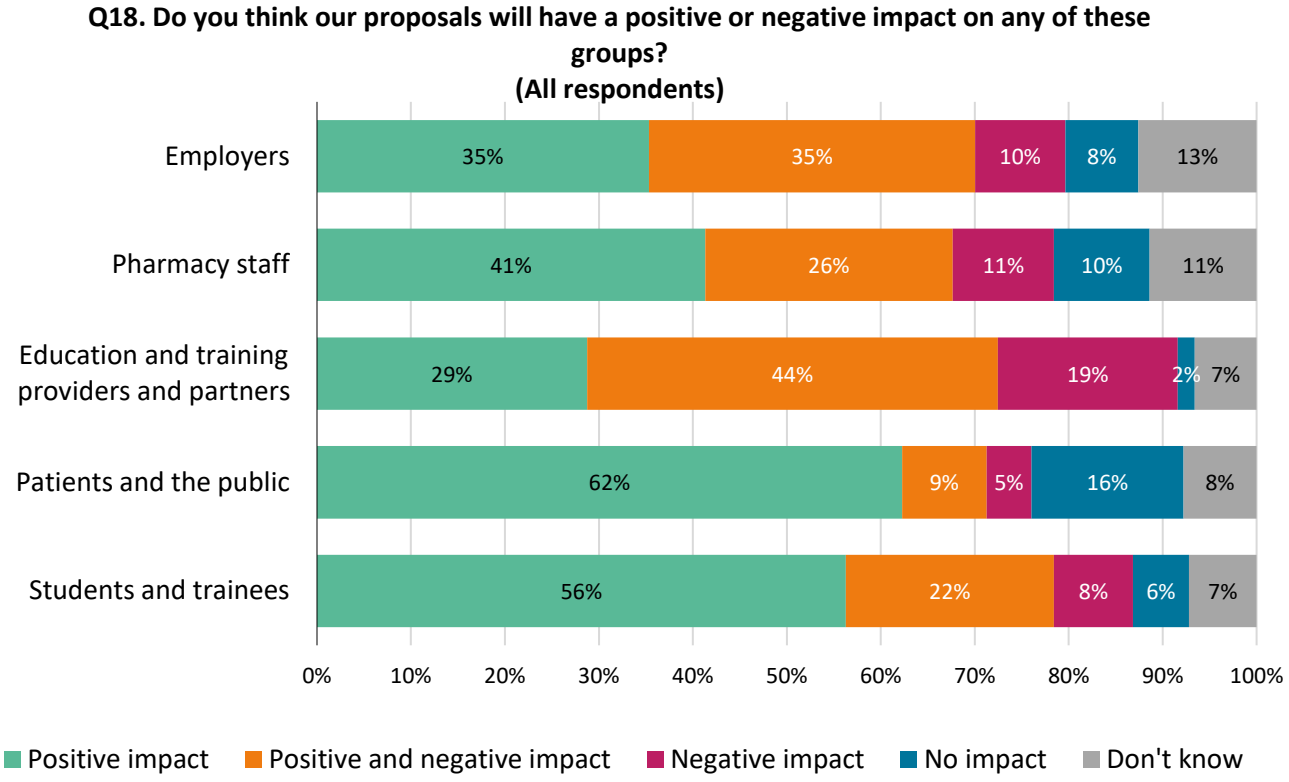


Figure 2 shows that many respondents thought that the proposals would have a positive impact on patients and the public (62%). Slightly fewer respondents felt that students and trainees (56%), would be positively impacted by the proposals. The fewest percent of respondents felt there would be a positive impact on education and training providers and partners (29%).

In contrast, a smaller proportion of respondents thought that the proposals would have a negative impact, with education and training providers and partners (19%) scoring the highest. A modest proportion of respondents indicated that the proposals would have both a positive and negative impact on the groups identified above, with education and training providers and partners (44%) again scoring the highest.

A small proportion of respondents (between 2% and 16%) thought the proposals would have no impact, with patients and the public (16%) being the highest in this section. Slightly more respondents indicated they did not know how the proposals would affect the above groups (between 7% and 13%).

A full breakdown of individual and organisational responses to this question is available in **Appendix 8**.

Just over half of all respondents left explanatory comments on the impact of the proposals. Set out below is an analysis of the top themes found in their responses.

## 5.2 Summary of themes

**Just over half of respondents left a comment relating to this section. Set out below is an analysis of the themes found in their responses.**

The majority of themes on the impact of the proposals were positive. The top positive themes found in this section were comments of general support, the improvements in the provision of education training

and the beneficial impact on students and the comments on improved quality of patient safety and care. Negative comments in this section were on the increased burden on providers and employers and the lack of clarity of the proposals and call for more information.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- Increased burden on providers and employers
- General support
- Lack of clarity
- Improves provision of education and training and the student experience
- No impact on those with protected characteristics and other groups
- Improves patient safety and care

## 5.3 Increased burden on providers and employers

These comments very closely reflected those outlined in the above sections (see 1.5, 2.7, 3.7 and 4.6). Once again respondents felt additional levels of data collection, paperwork and meetings would lead to increased amount of time, effort, workload, administration, implementation and cost. These respondents felt this would affect staff, education providers, the university sector, healthcare providers and employers. This would lead to increasing the levels of stress of individuals within the groups listed.

## 5.4 General support

The most common positive response of those who made comments, was general positivity about the impact of the proposals. This took the form of overall support with no specific details included in the comment. In this theme of general support, respondents said the proposals would have an overall positive impact and effect, that they would address problems and be of overall benefit. Others who responded to this section felt the proposals were good, that overall they were supportive, they could only see a positive impact on everyone, that they were good in general, of an overall benefit and mainly positive.

## 5.5 Lack of clarity

Lack of clarity and a call for more information was again a popular theme mentioned by respondents in this section. Broadly similar aspects to previous sections were mentioned in this theme such as types of data, benefits and resource implication (see 1.8, 2.3, 3.6 and 4.7 above). However, other aspects were specific to this section. In order to fully understand the impact of the proposals respondents called for clarity on how proposals would be implemented including tangible examples and details on process support.

Respondents again pointed to a lack of evidence including how the proposals would reduce the burden on education and training providers. Finally, a respondent asked for clarity on what would be published to the public domain.

## 5.6 Improves provision of education and training and the student experience

Another set of positive comments in this section referred to how the proposals would improve the provision of education and training and the student experience.

Respondents who made comments in this section suggested the proposals would have positive outcomes for everyone involved in pharmacy. Those delivering the training would be able to follow

agreed processes and procedures so that they would know what was required of them in order to deliver the course. The proposals would also give them added confidence and voice. While updating the education and training would incorporate new developments. Overall, this would lead to the quality of education and training improving.

Students and trainees would benefit from knowing that whatever course they were on, they could be confident that the GPhC had set high standards. Therefore, they would be able to choose any provider and feel confident that they have been measured and judged as suitable for delivering courses. This would be in the best interest of students reducing the impact of QA on them and producing well rounded and better educated graduates.

Respondents who left comments in this section believed the proposed changes would also lead to wider positive outcomes as quality assured education is of benefit to those undertaking it and paying to ensure delivery of good, safe practice and service. They felt employers would know they were employing a well-trained pharmacist or technician and their business would benefit from this. The better educated students would also enhance the standing of pharmacy overall.

Finally, some respondents felt a flexible approach would enable any concerns to be identified and managed at an early stage. Therefore, these proposals would help safeguard trainees and students who might be more vulnerable to discrimination and bullying by unscrupulous training providers.

### 5.7 No impact on protected characteristics and other groups

Some respondents to the questions on impact referred to how the proposals would have no impact on those sharing protected characteristics or those in specific groups. Those who commented on this section suggested that there was nothing in the proposals that would impact any groups either positively or negatively. Others highlighted specifically how individuals with protected characteristics would not be adversely affected by anything suggested in the proposals. Most respondents did not elaborate on the reasons why there would be no impact. However, those who did provide possible reasons suggested the level of data required under the proposals could in no way impact any of the individuals or groups listed, with others saying they could not see any current issues which might impact these groups. One respondent suggested that the absence of impact would depend on how the proposals are implemented with another suggesting there would be no impact if the GPhC ensured institutions were engaging with the processes suggested.

### 5.8 Improves patient safety and care

Of those who responded to this section another common positive theme was the impact the proposals would have on patient safety and care. The responses mostly did not offer specific details about how patient safety and care would be improved instead simply stating the proposals would improve standards and quality, have positive outcomes for patients, lead to benefits for patient safety or be in the best interest of patients.

However, other respondents were more specific. There was a suggestion among these that better assurance and increased accountability would lead to a growth in public trust in the pharmacy profession with this leading to positive outcomes. While others felt the proposals would help to build better teams and promote well-being which would translate into patients receiving the best care. Finally, some respondents believed enhanced support and greater feedback and discussions outlined in the proposals should lead to improved training and ultimately better patient care.

# 6. Additional themes and other suggestions

The most common themes for each question have been explored in the body of the report. However, there were a wide range of other themes that were raised in the consultation, some of which came up across multiple sections. This is a summary of the additional themes which were raised during the consultation but were not the most common in each section.

## 6.1 Summary of additional themes

The additional themes raised in the consultation were equally split between positive and negative. Six of the themes raised were positive and six negative. The top additional theme was positive and suggested the proposals reduced provider burden. The second most popular theme was negative, with those who mentioned this theme believing the proposals were less efficient and duplicated existing processes. Several of the themes related to the impact of the proposals on those sharing protected characteristics and other groups with a mixture of positive and negative viewpoints.

### Positive comments

Respondents stated that the proposals:

- outlined processes which were proportionate, limited, effective and efficient, that would keep impact on delivery of education and training to a minimum and reduce provider burden.
- helped bring GPhC QA in line and adapt to current and future changes in pharmacy roles, the pharmacy profession and continuing professional development (CPD) requirements.
- suggested the right approach to data with the right data, an appropriate mix of data and a good range of data, used in the right way.
- assured the public, patients and GPhC stakeholders that standards would be met and continue to be met.
- offered greater support to providers, the workforce and stakeholders.
- would have a positive impact on those with protected characteristics, particularly students, through better identification of individual needs and targeted support, bridging the attainment gap and bias awareness.

### Negative comments

Respondents stated that the proposals:

- would create a more reactive and less efficient system which duplicated or overlapped existing processes.
- failed to engage with or failed to engage enough with a range of other pharmacy related groups such as pharmacy assistants, users, other frontline staff and newly qualified pharmacists.
- would have a negative impact on students with the additional activities taking staff away from providing education and training, an added additional burden on students and an impact on student retention and progression in the industry if results were published.
- would have a negative impact on specific groups, including those with mental health conditions, and women due to them working part-time more often and family commitments.
- did not go far enough and there should be a more interventionist approach. This included, that the proposals provided insufficient guidance, advice, support and administrative support, work at preliminary stages, regular audits or serious enough sanctions. They also felt the proposals did

not go far enough in changing the relationship between universities and GPhC or supporting programmes to develop in ways which deviate from university standard rules.
- did not address inconsistencies in provision and needed to align pharmacy clinical knowledge between universities and teaching standards across pharmacy technician training programmes.

## 6.2 Other suggestions

A range of suggestions for alternative approaches to quality assurance of pharmacy education and training also appeared in the comments of the online survey. These suggestions were often quite detailed, specific or specialised and did not directly relate to the four specific areas dealt with in the proposal. It was therefore not possible to group the suggestions thematically and so they have not been included in this report. However, these comments were collated and passed on to the education team for further review.

# Appendix 1: Summary of our proposals

## 1. Yearly monitoring

Part of the proposal is to introduce a yearly monitoring process to improve the quality assurance of pharmacy education and training. As part of this process better use will be made of data. Information which individual providers will be asked to provide include comments on:

- the management, oversight and delivery of education and training
- changes affecting education and training, such as changes in staffing, infrastructure or financial resources
- the delivery of experiential and inter-professional learning during the academic year
- key themes coming from stakeholder feedback, including students, trainees, supervisors and patients
- outcomes from internal and external quality assurance, such as independent appraisals and external examiner reports
- provider analysis of student/ trainee admissions and performance data, including equality monitoring data, and
- reflection on GPhC registration assessment performance data, including action plans where appropriate

Data from other sources will also be considered, such as National Student Surveys (NSS) and student and trainee feedback collected by the GPhC. The yearly monitoring process will build upon the existing yearly data collection processes and timings, so that there is a single reporting point each year. This will allow for a more tailored approach to the timing of the approval activities. The GPhC will be able to adapt the current three-yearly event cycle, so that timings between events can be changed based on the outcome of yearly monitoring. It will help everyone involved in the quality assurance of pharmacy education and training to maintain oversight. It will also help the regulator to spot and deal with concerns early.

The overall aim is to assure patients and the public that GPhC standards and requirements for education and training continue to be met.

## 2. Intervention, escalation and decision-making

As part of reviewing the information that the GPhC gathers during yearly monitoring, the regulator will need good decision-making and appropriate ways of dealing with concerns. Therefore, the following four intervention activities are proposed to be carried out by appropriate teams (the GPhC Quality Assurance team, the Approval team or both):

- asking the provider for more evidence and information (for example, action plans)
- helping the provider with a quality management activity (for example, assessment standard setting)
- having a focused meeting with the provider (for example, a conversation about the concern), and
- carrying out a focused activity with the provider (for example, a visit or observing teaching)

These activities will help the GPhC make sure that any concerns are dealt with in the most effective ways and that their impact on the delivery of education and training is as low as possible.

### 3. Increased flexibility for approval and intervention

The proposed update to the quality assurance of education and training will give the GPhC more flexibility in the way pharmacy course provision is approved. The regulator will be able to intervene when concerns are identified, and work with providers to help deal with these quickly. Equally, because of the flexibility that the GPhC will have with the proposed yearly monitoring and intervention processes, there will no longer be a need for the regulator to publish an 'end date' for the education and training approved.

The GPhC would still expect there to be an event every three years, as is currently the case. However, the timing of events can change based on satisfactory yearly monitoring and/or the outcomes of interventions. These may delay an interim or reapproval event by one or more academic years, as satisfactory outcomes may give GPhC sufficient assurance. This could reduce the need for an approval event to every three years.

However, if there are unsatisfactory monitoring or intervention outcomes, the GPhC may need to schedule extra meetings or events. These are likely to be on top of the usual reapproval or interim events. This would give GPhC the level of scrutiny needed to work with the provider and deal with concerns quickly.

### 4. Applying the same quality assurance processes across all pharmacy education and training

Pharmacy technician and pharmacy support staff qualifications are delivered and overseen by national awarding organisations. Currently, the GPhC reapproves these courses and qualifications using a six-year cycle, with an interim event every three years. This is also the case for Master of Pharmacy (MPharm) degrees delivered by higher education institutions. However, pharmacy technician and pharmacy support staff courses that are delivered by private providers do not have this quality oversight from other organisations. For this reason, the GPhC reapproves these using a three-year cycle. This reapproval arrangement also applies to the pharmacist independent prescribing programmes delivered by higher education institutions.

By introducing yearly monitoring, the GPhC will have greater oversight of all courses of pharmacy education and training. Therefore, it is proposed to apply to private providers and pharmacist independent prescribing providers the same arrangements that apply to, for example, national awarding organisations and MPharm providers. In effect, this will result not only in greater scrutiny but in a consistent quality assurance approach overall, meaning that any pharmacy course or qualification approved by the GPhC will be subject to yearly monitoring, interim events and reapproval events.

# Appendix 2: About the consultation

## Overview

The consultation was open for 11 weeks, beginning on 4th April 2024 and ending on 13 June 2024. To make sure 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 events aimed at pharmacy professionals, pharmacy service users, organisations and other interested parties. These included the following:
    - Focus group with Patient and Public Voice
    - Focus group with Student Voice (students and trainees)
    - Webinar (open to stakeholders)
    - Focus group with pre-registration trainee pharmacy technicians
- we promoted the consultation through a press release to the pharmacy trade media, and via our social media.

## Survey

We received a total of **167** written responses to our consultation. **122** of these respondents identified themselves as individuals and **45** responded on behalf of an organisation. The vast majority of these respondents completed the online version of the survey, with the remaining respondents submitting their response by email, using the structure of the consultation questionnaire.

## Stakeholder events

We held **4** stakeholder events. These were attended by a mix of pharmacists, pharmacy technicians, people working in education and training, employers, pre-registration pharmacists, and representatives from professional bodies and trade bodies.

We organised:

- Focus group with patients and the public on 7 May 2024 attendance **14**
- Focus group with students and trainees on 14 May 2024 attendance **8**
- Focus group with pre-registration trainee pharmacy technicians on 22 May 2024 **6**
- Webinar on 16 May 2024 attendance **69**

**97** individuals and representatives of organisations participated in these events.

## Social media

We monitored social media activity during the consultation period. No feedback was received for inclusion in our consultation analysis.

# Appendix 3: Our approach to analysis and reporting

## Overview

Every response received during the consultation period in surveys 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.

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.

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.

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

Full details of the profile of respondents to the online survey is given in **Appendix 4**.

For transparency, **Appendix 5** provides a list of the organisations that have engaged in the consultation through the online survey and email responses. A small number of organisations asked for their participation to be kept confidential and their names have been withheld.

The consultation questions are provided in **Appendix 6**.

## Quantitative analysis

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 using the consultation document.

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 been presented alongside each other in the tables throughout this report, in order to help identify whether there were any substantial differences between these categories of respondents.

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.

Percentages are shown without decimal places and have been rounded to the nearest whole number. As a result, some totals do not add up to 100%. This rounding also results in differences of up to one percentage point when combining two or more response categories. Figures of less than 1% are represented as <1%.

All questions were mandatory and respondents had the option of selecting ‘don’t know’. Routing was used where appropriate to enable respondents to skip questions that weren’t relevant. Skipped responses are not included in the tables for those questions.

## Qualitative analysis

This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses and those received by email, including those from individuals and organisations.

The qualitative nature of the responses here meant that we were presented with a variety of views, and rationales for those views. Responses were carefully considered throughout the analysis process.

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.

Prevalence of views was identified through detailed coding of written responses using the themes from the coding framework. The frequency with which views were expressed by respondents is indicated in this report with themes within each section presented in order of prevalence. The use of terms also indicates the frequency of views, for example ‘many’/’a large number’ represent the views with the most support amongst respondents. ‘Some’/’several’ indicate views shared by a smaller number of respondents and ‘few’/’a small number’ indicate issues raised by only a limited number of respondents. Terms such as ‘the majority’/’most’ are used if more than half of respondents held the same views. NB. This list of terms is not exhaustive and other similar terms are used in the narrative.

## The consultation survey structure

The consultation survey was structured in such a way that open-ended questions followed each closed question or series of closed questions on the consultation proposals. This allowed people to explain their reasoning, provide examples and add further comments.

For ease of reference, we have structured the analysis section of this report in such a way that it reflects the order of the consultation proposals. This has allowed us to present our quantitative and qualitative analysis of the consultation questions alongside each other, whereby the thematic analysis substantiates and gives meaning to the numeric results contained in the tables.

# Appendix 4: 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 in what sector they usually worked. For individuals working in community pharmacy, they were asked the size of pharmacy chain. For organisational respondents, there were questions about the type of organisation that they worked for. The tables below present the breakdown of their responses.

## Category of respondents

**Table 13:** Responding as an individual or on behalf of an organisation (Base: all respondents)

| Are you responding: | Total N | Total % |
|---|---|---|
| **As an individual** | 122 | 73% |
| **On behalf of an organisation** | 45 | 27% |
| **Total N and % of responses** | **167** | **100%** |

## Profile of individual respondents

**Table 14:** Countries (Base: all individuals)

| Where do you live? | Total N | Total % |
|---|---|---|
| **England** | 106 | 87% |
| **Scotland** | 10 | 8% |
| **Wales** | 3 | 2% |
| **Northern Ireland** | 1 | 1% |
| **Other** | 2 | 2% |
| **Total N and % of responses** | **122** | **100%** |

**Table 15:** Respondent type (Base: all individuals)

| Are you responding as: | Total N | Total % |
|---|---|---|
| **a pharmacist?** | 78 | 64% |
| **a pharmacy technician?** | 35 | 29% |
| **a student or trainee pharmacist?** | 1 | 1% |
| **a pharmacy support staff trainee?** | 1 | 1% |
| **a member of the public?** | 1 | 1% |
| **other?** | 6 | 5% |
| **Total N and % of responses** | **122** | **100%** |

**Table 16:** Main area of work (Base: individuals excluding pharmacy students and members of the public)

| Sector | Total N | Total % |
|---|---|---|
| **Hospital pharmacy** | 35 | 29% |
| **Research, education or training** | 32 | 27% |
| **Community pharmacy (including online)** | 27 | 23% |
| **GP practice** | 12 | 10% |
| **Primary care organisation** | 3 | 3% |
| **Pharmaceutical industry** | 2 | 2% |
| **Other** | 8 | 7% |
| **Total N and % of responses** | **119** | **100%** |

**Table 17:** Size of community pharmacy (Base: individuals working in community pharmacy)

| Size of pharmacy chain | Total N | Total % |
|---|---|---|
| **Independent pharmacy (1 pharmacy)** | 4 | 15% |
| **Independent pharmacy chain (2-5 pharmacies)** | 4 | 15% |
| **Small multiple pharmacy chain (6-25 pharmacies)** | 2 | 7% |
| **Medium multiple pharmacy chain (26-100 pharmacies)** | 3 | 11% |
| **Large multiple pharmacy chain (Over 100 pharmacies)** | 14 | 52% |
| **Total N and % of responses** | **27** | **100%** |

## Profile of organisational respondents

**Table 18:** Type of organisation (Base: all organisations)

| Please choose the option below which best describes your organisation | Total N | Total % |
|---|---|---|
| **Research, education or training organisation** | 22 | 49% |
| **Organisation representing pharmacy professionals or the pharmacy sector** | 9 | 20% |
| **NHS organisation or group** | 7 | 16% |
| **Registered pharmacy** | 2 | 4% |
| **Government department or organisation** | 1 | 2% |
| **Other** | 4 | 9% |
| **Total N and % of responses** | **45** | **100%** |

## Monitoring questions

Data was also 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 has been carried out and will be published alongside this analysis report.

# Appendix 5: Organisations

The following organisations engaged in the consultation through the online survey and email responses:

Association of Pharmacy Technicians UK

Aston University Pharmacy School

Bangor University

Boots UK

Bradford Teaching Hospitals NHS Foundation Trust

Broughton Park Pharmacy Ltd

Cardiff University School of Pharmacy

Community Pharmacy Scotland

Community Pharmacy Wales

Cumberland Infirmary Carlisle, North Cumbria Integrated Care

De Montfort University

Directors of Pharmacy, Scotland

Health Education & Improvement Wales

Healthcare Improvement Scotland

King's College London

Medway School of Pharmacy

National Pharmacy Association

NHS Education for Scotland

NHS Grampian

NICPLD

Open Awards

Oxford Health NHS Foundation Trust

Pharmacist Support

Pharmacy Schools Council

Pharmacy Technician Education & Training Strategic Group Scotland

Queen's University Belfast

Royal Pharmaceutical Society

Scottish Practice Pharmacy & Prescribing Advisers Association

Sheffield Hallam University

SQA

Swansea University

The Pharmacists' Defence Association

The University of Manchester (Independent Prescribing Programme)

The University of Manchester (Pharmacy School)

UCL

University of Bradford

University of Brighton

University of Nottingham

University of Reading

University of Strathclyde

Workforce, Training & Education, NHS England

# Appendix 6: Consultation questions

Q1: To what extent do you agree or disagree that we should introduce yearly monitoring to help bridge the present gaps between interim and reapproval events?

Q2: To what extent do you agree or disagree that the proposed areas (listed on page 16 of the consultation) should be considered in the yearly monitoring of providers of all education and training?

Q3: As well as considering the areas listed on page 16 of the consultation, we are proposing to collect more data. This will help us develop the evidence base we use as part of our quality assurance and give us a more all-round view of the evidence. To what extent do you agree or disagree, in each case, that the following sets of data will strengthen the quality assurance of education and training?

a) Student and trainee feedback collected by the GPhC.
b) National Student Surveys (NSS), Post Graduate Taught (PGT) surveys and equivalent subject-level data.
c) GPhC registration assessment performance data (pharmacist initial education and training only).
d) Oriel assessment performance data (pharmacist initial education and training only).
e) Other data (for example, upheld education concerns).

Q4: To what extent do you agree or disagree that the proposed yearly monitoring process will provide sufficient quality assurance between interim and reapproval events?

Q5: Please give your comments explaining your answers to the above four questions about our proposals for yearly monitoring.

Q6: We are proposing four intervention activities to make sure that any concerns are dealt with in the most effective ways to keep their impact on the delivery of education and training as low as possible. To what extent do you agree or disagree that, in each case, the following interventions will strengthen the quality assurance of education and training?

a) Asking the provider for more evidence and information (for example, action plans).
b) Helping the provider with a quality management activity (for example, assessment standard setting).
c) Having a focused meeting with the provider (for example, a conversation about the concern).
d) Carrying out a focused activity with the provider (for example, a visit or observing teaching).

Q7: To what extent do you agree or disagree that the teams allocated to each type of intervention activity are appropriate decision makers? (Please see figure 5 on page 20 of the consultation).

Q8: Please give your comments explaining your answers to the above two questions about our proposals around intervention and decision-making.

Q9: To what extent do you agree or disagree with taking a flexible approach to the timing of interim and reapproval events, meaning that these will not be limited to taking place once every three or six years?

Q10: To what extent do you agree or disagree with taking a variable approach to the periods of approval, meaning that approval status will not have a set end date but will depend on the outcome of the next planned interim and reapproval events?

Q11: To what extent do you agree or disagree that a QA intervention activity should be carried out as a result of an unsatisfactory yearly monitoring outcome?

Q12: To what extent do you agree or disagree that a QA event (interim, exceptional interim, or reapproval) should be held as a result of an unsatisfactory QA intervention activity outcome?

Q13: Please give your comments explaining your answers to the above four questions about our proposals around flexible and continual approval.

Q14: To what extent do you agree or disagree with our proposal to apply our QA processes so that arrangements that apply to national awarding organisations also apply to private providers of pharmacy technician and support staff courses?

Q15: To what extent do you agree or disagree with our proposal to apply our QA processes so that arrangements that apply to MPharm providers also apply to providers of independent prescribing programmes?

Q16: Please give your comments explaining your answers to the above two questions about applying our processes across all pharmacy education and training.

Q17: Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the protected characteristics?

Q18: Do you think our proposals will have a positive or negative impact on any of these groups (employers, pharmacy staff, education and training providers and partners, patients and the public, students and trainees)?

Q19: Please give your comments explaining your answers to the two questions above. Please describe the individuals or groups concerned and the impact you think our proposals will have.

# Appendix 7: The impact of the proposed changes on people sharing protected characteristics

## Individual responses

**Figure 3:** Views of individual respondents (N = 122) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

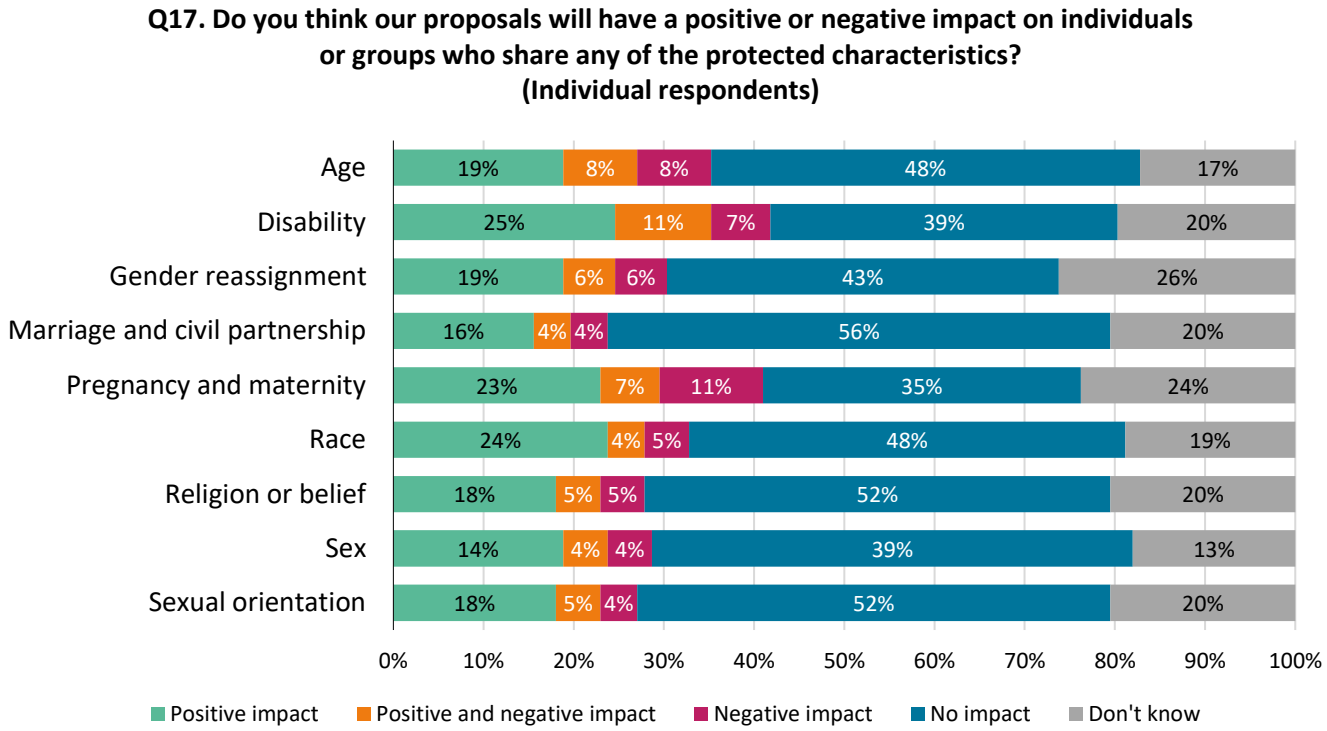


Figure 3 shows that the highest percentage of individual respondents (ranging from 35% to 56%) felt that our proposals would have no impact on each of the protected characteristics.

Between 14% and 25% of respondents felt there would be a positive impact on groups or individuals who share any of the nine protected characteristics. The protected characteristic that individual respondents thought would have the largest positive impact was disability (25%). A similar proportion (between 13% and 26%) did not know what the impact of the proposals would be.

Only a small proportion of individuals (between 4% and 11%) felt that the proposals would have a negative impact on people sharing one or more of the nine protected characteristics, with pregnancy and maternity (11%) scoring the highest in this category. A similar range of individual respondents (ranging from 4% to 11%) indicated that the proposals would have both a positive and negative impact on each of the protected characteristics.

NB. Please see section 5 in the main body of the report for the chart showing the overall responses and further analysis.

## Organisational responses

**Figure 4:** Views of organisations (N = 45) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

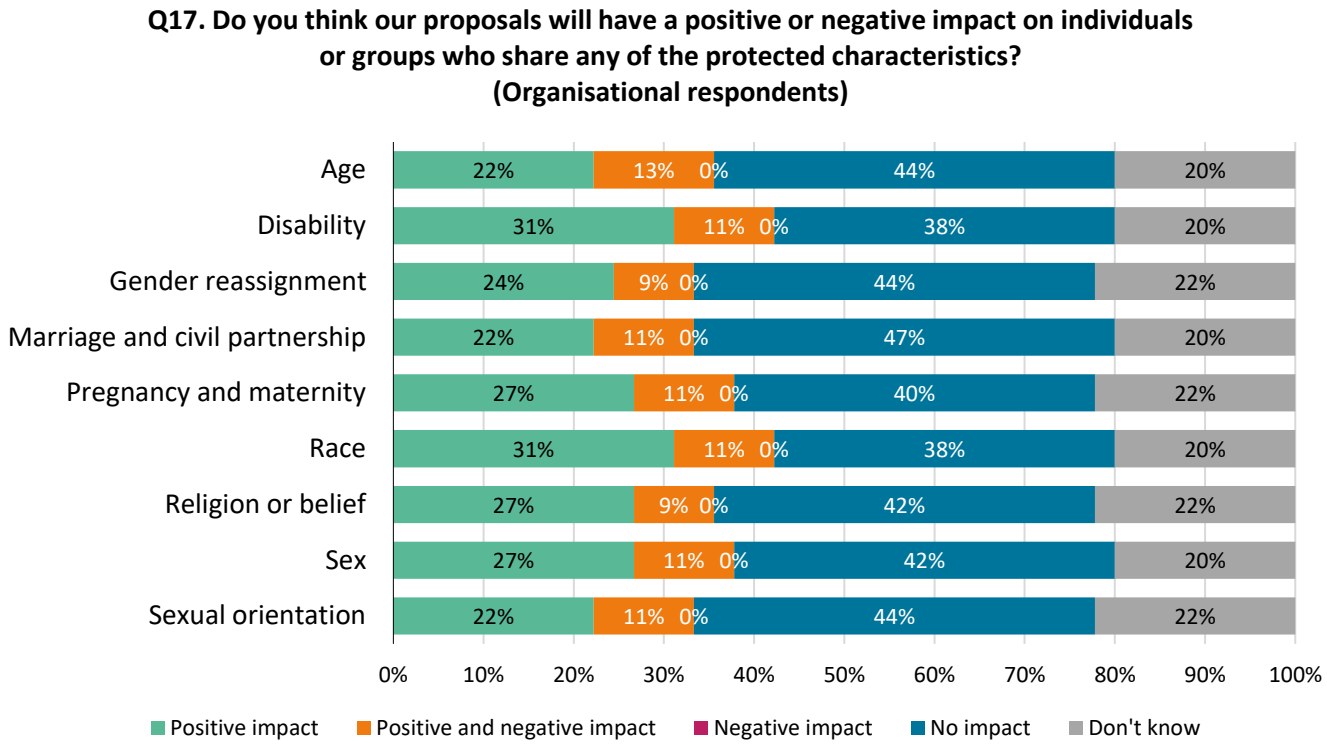


Figure 4 shows that the highest percentage of organisations (ranging from 38% to 47%) felt that our proposals would have no impact on each of the protected characteristics.

Between 22% and 31% of organisational respondents felt there would be a positive impact on groups or individuals who share any of the nine protected characteristics. The protected characteristic that organisations thought would have the largest positive impact was race (31%). A smaller and uniform proportion (between 20% and 22%) did not know what the impact of the proposals would be.

No organisations s felt that the proposals would have a negative impact on people sharing one or more of the nine protected characteristics. More organisational respondents (ranging from 9% to 13%) indicated that the proposals would have both a positive and negative impact on all of the protected characteristics.

NB. Please see section 5 in the main body of the report for the chart showing the overall responses and further analysis.

# Appendix 8: The impact of the proposed changes on other groups

## Individual responses

**Figure 6:** Views of individual respondents (N = 122) on whether our proposals positively or negatively impact other individuals or groups

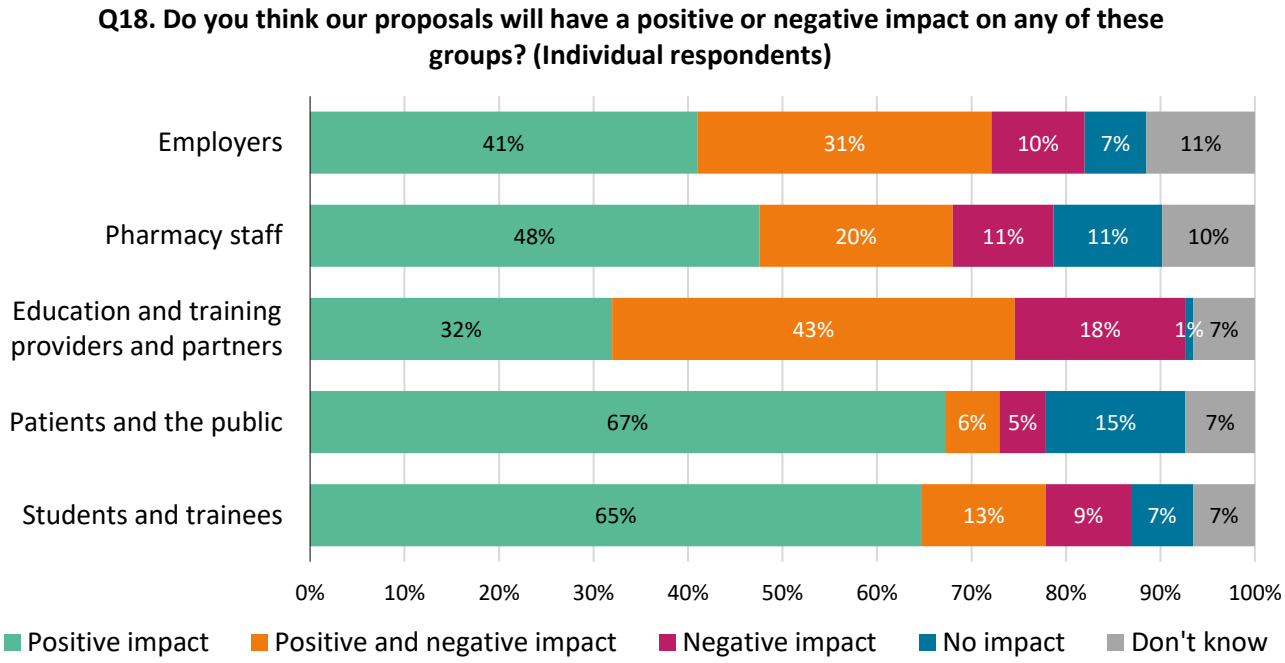


Figure 6 shows that many individual respondents thought that the proposals would have a positive impact on patients and the public (67%). Slightly fewer felt that students and trainees (65%) would be positively impacted by the proposals. The fewest percent of individual respondents felt there would be a positive impact on education and training providers (32%).

In contrast, a smaller proportion of individuals thought that the proposals would have a negative impact, with education and training providers (18%) scoring the highest. A higher proportion indicated that the proposals would have both a positive and negative impact on the groups identified above, with education and training providers (43%) again scoring the highest.

A small proportion of individuals (between 1% and 15%) thought the proposals would have no impact, with patients and the public (15%) being the highest. A slightly more uniform proportion indicated they did not know how the proposals would affect the above groups (between 7% and 11%).

NB. Please see section 5 in the main body of the report for the chart showing the overall responses and further analysis.

## Organisational responses

**Figure 7:** Views of organisations (N = 45) on whether our proposals positively or negatively impact other individuals or groups

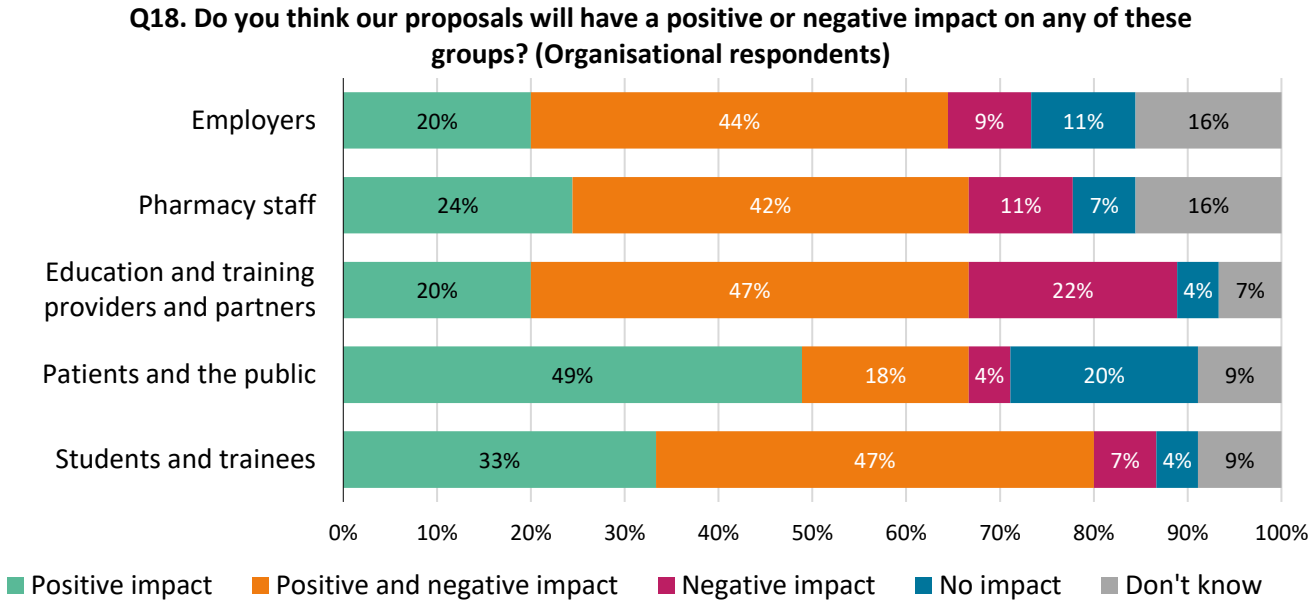


Figure 7 shows that just under half of organisations thought that the proposals would have a positive impact on patients and the public (49%), with the fewest percent of organisations believing there would be a positive impact on education and training providers (20%) and employers (20%).

In contrast, a smaller proportion of organisations thought that the proposals would have a negative impact (4% to 22%), with education and training providers (22%) scoring the highest. The highest proportion of organisations indicated that the proposals would have both a positive and negative impact on the groups identified above (18% to 47%), with education and training providers (47%) and Students and trainees (47%) scoring the highest.

A proportion of organisations (between 4% and 20%) thought the proposals would have no impact, patients and the public (20%) being the highest. Slightly more indicated they did not know how the proposals would affect the above groups (between 7% and 16%).

NB. Please see section 5 in the main body of the report for the chart showing the overall responses and further analysis.