Consultation on the initial education and training standards for pharmacists: Analysis report

Contents

Executive summary

Background

Between January and April 2019, we **consulted on changes to our standards for the initial education and training of pharmacists**. There were six main areas on which we were seeking views. These were:

- Revising the learning outcomes so that they are more focused on developing clinical and communication skills, while still retaining the critical importance of science

- Revising the standards for education and training providers, including strengthening our requirements regarding equality, diversity and fairness

- Having one set of standards and learning outcomes that cover the full period of education and training before initial registration as a pharmacist, with closer integration between academic study and practical experience

- Strengthening our requirements in relation to selection and admission

- Strengthening experiential learning and inter-professional learning

- Requiring a more rigorous and structured approach to the supervision of learning in practice (currently known as pre-registration training) with more regular and documented progress meetings

We delivered the consultation through an online survey and held events for stakeholders and patients and members of the public in England, Scotland and Wales. We also organised many one-to-one meetings with organisations.

There were 650 responses to the consultation: 108 from organisations and 542 from individuals.

144 individuals and representatives of organisations attended three stakeholder events and three patient focus groups. We also presented at 33 events across England, Scotland and Wales, reaching 1,310 stakeholders including pharmacy professionals, education providers, employers, students and pre-registration trainees. We also hosted an online webinar, which was viewed by 900 stakeholders.

Key issues raised in responses

General view

Our proposals are designed to ensure that pharmacists are equipped with the knowledge, skills, attitudes and behaviours to practise safely and effectively as pharmacy professionals, and that their education and training take into consideration the evolution of pharmacy services. Overall, respondents were broadly supportive of our proposals while making a number of suggestions and raising a number of questions, particularly about how the integration of academic and practical learning would be implemented.

Views on the learning outcomes

There was broad support for the learning outcomes set out in the consultation focusing on person-centred care; professionalism; professional knowledge and skills; and collaboration.

Most respondents found the learning outcomes clear, ambitious and agreed they captured the knowledge, skills, attitudes and behaviours pharmacists need to practise. They welcomed the stronger emphasis placed on communication with both patients and the multi-disciplinary team, and on clinical skills. Respondents also emphasised the importance of retaining the focus on developing scientific knowledge in pharmacists' initial education and training.

Many detailed responses identified a need to clarify the meaning of certain outcomes and to provide a greater focus on technology and on leadership.

Views on prescribing-related skills

A large number of respondents were in favour of our proposals to strengthen prescribing-related skills in the initial education and training of pharmacists. For them, incorporating pre-prescribing skills in the undergraduate degree would enable newly registered pharmacists to train as independent prescribers sooner. These respondents found clinical examination skills and diagnostic skills particularly useful. Several responses also underlined the need to take the use of electronic prescribing systems into consideration. Other respondents wondered whether pharmacists should be prescribing ready on day one.

Views on the standards for providers

A large majority of consultation respondents felt that our standards for providers were appropriate and welcomed the strengthened requirements in regard to equality, diversity and fairness and requiring providers to carry out an annual review of student performance and admissions using the protected characteristics defined by the Equality Act 2010.

Other respondents made specific recommendations or asked for clarification on the standards focusing on resources and capacity; managing, developing and evaluating initial education and training; curriculum design and delivery; assessment; and support and development for student pharmacists and people delivering initial education and training.

Views on the integration of the five years of initial education and training

The majority of consultation respondents supported the principle of integration. Most respondents recognised the benefits to learning from integrating academic study and practical experience. They

indicated that it would raise the quality of initial education and training of pharmacists thanks to the earlier application of knowledge in practice and interactions with patients and health and care professionals. However, many responses were unsure about how integration would be implemented and were concerned about its funding.

Views on selection and admission requirements

There was broad support for our proposals to require universities to assess the professional skills and attributes of prospective students as well as their academic qualifications with interactive elements built into the admissions process, while recognising that students develop over the course of their education and training. Some respondents questioned how our proposed admissions requirements would apply during Clearing and others mentioned the costs associated with our proposed changes.

There were mixed views about whether the GPhC should be more prescriptive in setting admission standards, whereby only those students who achieved the advertised grades should be admitted onto the course, and whether unconditional offers should be allowed. However, the need for consistency between requirements from all education providers was a common theme in many responses.

Many respondents also made suggestions on the skills and attributes that should be assessed in applicants and the format of assessments.

There was broad agreement that selection and admission procedures should be inclusive and not negatively impact applicants from any groups.

Views on experiential learning and inter-professional learning

The vast majority of respondents approved of the increase of experiential and inter-professional learning in the initial education and training of pharmacists. This would enable students to achieve a higher level of competence and to become more effective and confident professionals. Respondents highlighted that, as the pharmacist's role becomes more clinical and embedded in multi-disciplinary teams, it was important for students to be exposed to patients and to interact with colleagues at an earlier stage of their education and training. Many responses underlined the importance of consistency in these two areas between education providers and some respondents asked for clarification of the standard expected.

Views on learning in practice supervision

Many respondents were in favour of our proposals for learning in practice, agreeing that more regular and documented progress meetings would better support students' progression, ensure more consistency in the supervision of students and improve the quality of training. There was broad support for adopting a more tailored approach to students' needs.

Many suggestions were made to ensure the continuity of students' supervision between education and training or between practice supervisors. Propositions were also made regarding the training of supervisors. Respondents also required further clarifications on implementation and expressed concerns about funding.

Key issues raised by country

England

Over 80% of consultation respondents were based in England. The section 'Key issues raised in responses' is therefore representative of the view of English respondents.

Scotland

Scottish respondents proposed to include or strengthen in the learning outcomes, empathy, ethics, dealing with vulnerable groups, resilience, risk management and encouraging the development of a learning culture in the profession.

Most Scottish respondents welcomed the integration of academic study and practice learning, mentioning that it would standardise and increase the quality of education and training and ensure close collaboration between stakeholders delivering education and training. Several Scottish respondents also expressed concerns about the implications of integration on students. A few felt that a longer period of learning in practice should take place at the end of the initial education and training to allow students to apply their knowledge in practice.

Many Scottish respondents felt that because the pharmacist profession was patient-facing, grades alone could not demonstrate the suitability of an individual for entry into the profession. For them, admission procedures should also assess the skills, attributes, personal qualities, values and behaviours of applicants. They also explained that, in Scotland, unconditional offers were offered after school leavers achieve the required academic criteria.

Scottish respondents welcomed our proposals for experiential learning, inter-professional learning and learning in practice. In their view, it was important to adequately train and support supervisors, document progression meetings and quality assure learning in practice.

Wales

Welsh respondents welcomed the learning outcomes, commented positively on the people-centred approach and made specific propositions to remove some duplication or to change the level of specific learning outcomes. They also suggested referring to people's mental health in the learning outcomes.

Welsh respondents were supportive of integrating academic study with practice learning and thought that it would increase students' confidence and communication skills and make them better pharmacists. They were, however, concerned about financial arrangements and the impact of integration on students. Welsh respondents felt it was important for learning in practice placements to take place in several sectors and to establish efficient communication channels between education and training providers.

Most Welsh respondents agreed about assessing the skills and attribute of applicants as they felt that only a more holistic approach would ensure that those most suited to the profession entered onto MPharm degrees. They favoured a collaborative approach and proposed to involve employers, patients and members of the public in the interactive components of admission procedures. Many Welsh respondents also felt that unconditional offers should be disallowed.

Welsh respondents felt that our proposed changes for experiential and inter-professional learning would be beneficial to future pharmacists.

Welsh respondents agreed that regular and documented progress meetings would be beneficial as they would enable supervisors to better support students. A small number of Welsh respondents felt that students should be signed off by more than one supervisor.

Northern Ireland

The Pharmaceutical Society of Norther Ireland (PSNI) and the GPhC co-operate in line with the principle of mutual recognition and free movement of students, trainees and pharmacists as between Northern Ireland and Great Britain. The GPhC does not regulate Northern Ireland. We, however, accredit the two MPharm degrees of Queen's University Belfast and Ulster University and therefore engaged with Northern Irish stakeholders during the consultation.

Northern Irish respondents welcomed learning outcomes strengthening clinical, communication and research skills, and felt that the learning outcomes should specifically refer to prescribing or pre-prescribing skills.

Regarding selection and admission, many Northern Irish respondents considered that skills and attributes could be learnt for the selection process and that school leavers could be trained to produce appropriate answers. They were concerned that private organisations would start offering training programmes for the applicants who could afford it and that this would create more elitism.

There was general agreement in Northern Irish responses for the integration of academic study with practice learning and for strengthening of experiential and inter-professional learning. Northern Irish respondents, however, requested more clarity on funding streams to enable the implementation of these proposals and did not think that standards could be set in isolation to the funding process.

Northern Irish respondents also approved of replacing the pre-registration performance standards by the learning outcomes but were unsure about the willingness of the community sector to implement our proposed changes for learning in practice.

Key issues raised by type of respondents

Patients and members of the public

Patients and members of the public were in general supportive of the learning outcomes. They welcomed the increased focus on person-centred care and on empowering people in making decisions about their care. They thought more emphasis should be given to empathy, communication and listening skills in the learning outcomes.

Patients and members of the public were in favour of integrating academic study with practice learning, felt that students should experience several pharmacy environments during their placements and that placements should be organised from an early stage in the initial education and training of pharmacists.

Patients and members of the public agreed with our proposals for selection and admission, although they highlighted that the young age of applicants and widening participation should be taken into account. Many believed that applicants needed to have a minimum level of knowledge and competence to successfully graduate and it was unfair for universities to enrol students who would not be able to graduate. In order not to disadvantage any applicants, patients and members of the public proposed that the applicants, who were not able to travel to schools of pharmacy for the interactive component of admission procedures, should be assessed through Skype, for example. A significant number of

patients and members of the public were against unconditional offers as they felt unconditional offers acted as a disincentive for pupils to achieve their highest standards and affected public confidence in pharmacists.

Patients and members of the public supported our proposals regarding experiential and inter-professional learning.

They agreed about replacing the four tutor sign-offs by regular progress meeting. In their view, schools monitoring progress meetings would ensure students' progression and provide mediation in case of disagreements between students and their supervisors.

Schools of pharmacy

The majority of schools of pharmacy felt the revised learning outcomes were largely appropriate and made suggestions for particular additions and clarifications. Their most frequent comment was that the number of learning outcomes focusing on pharmaceutical sciences was too low. They felt that the learning outcomes should specify which scientific disciplines should be covered in the initial education and training of pharmacists. Several schools asked for guidance, examples or expectations on how the learning outcomes should be implemented as they found them non-specific. A small number of schools also mentioned that the shift of several learning outcomes from 'Shows How' to 'Does' would require further financial investment.

Although two-third of schools agreed that students' learning should be seen as a continuum between academic and practice learning, many of them did not think our proposed changes could be implemented without additional funding. A significant number of schools highlighted the potential additional costs associated with offering an integrated MPharm degree (including administrative management of the programme, appointment of new staff and quality assurance of learning in practice.) and were concerned some universities would stop offering MPharm degrees if they considered them as no longer viable. They also did not think students should pay for a fifth year of education and training as it would make pharmacy education much less attractive. Many schools asked for government funding to be explicitly confirmed before making changes to the standards for initial education and training. Several schools also asked for more clarity on responsibilities and accountabilities in an integrated model. They were unsure whose institution would be responsible for approving learning in practice training sites and supervisors, overseeing and quality assuring learning in practice. A number of schools thought a centralised infrastructure for learning in practice should be created. In their view, schools creating their own partnerships with training providers would be resource intensive and would lead to variations in quality of learning in practice. They suggested the creation of a learning in practice infrastructure, as for instance a Deanery infrastructure, which would apply at national or regional levels, to administer, monitor and quality assure learning in practice placements. In the education and training of other professions, Deaneries are local units, which are responsible for implementing specialty/advanced training in accordance with regulators' approved standards. They can sometimes set local policies and each of them are overseen by a postgraduate dean, who holds ultimate responsibility for the education and training of all students/trainees in that region.

Most schools agreed about the value of assessing the skills and attributes of prospective students and several of them said that their admission procedures already included interactive components. However, some schools were concerned about the financial impact of implementing our proposed changes regarding selection and admission, about the difficulty of organising the face-to-face assessment of applicants during Clearing and about widening participation. A few of them felt that the

young age of applicants should be taken into consideration in admission procedures. A number of schools felt that schools should continue to decide their own admission requirements and procedures, including the approach to unconditional offers.

Whilst the broad majority of schools agreed with the benefits of experiential learning and inter-professional learning, they asked for clarity about what was expected to meet the standards (volume and nature of such experiences, balance between simulated and in practice learning). Several schools said they believed the GPhC should set minimum requirements for experiential learning and inter-professional learning as they were concerned about inconsistency in delivery across education providers. Another concern shared by many of the schools was the cost associated with implementing our proposed changes in regard to experiential learning and inter-professional learning. They said that this would require additional funding. Several schools also set out that it was sometimes difficult to organise inter-professional learning activities with students from other professions because they had different structures of initial education and training. A number of schools proposed that the GPhC should engage with the regulators of these professions to ensure that the interprofessional emphasis of the proposed standards would be achievable.

Most schools agreed with the proposal to replace the four tutor sign-offs during pre-registration training with regular progress meetings as they felt this would improve the supervision of students. They felt the GPhC should set a minimum number of progress meetings or a minimum frequency between meetings as they found the phrase "more regular" too vague. Several schools asked how they should be involved in the progress meetings and expressed concerns about the costs associated with the oversight of the progress meetings. They also felt that the quality of the meetings was more important than their number and proposed that the schools and training providers formulated the purpose of the progress meetings in collaboration with the GPhC and set requirements for supervisors' training.

There was broad agreement on replacing the performance in practice pre-registration performance standards by the learning outcomes to align with modern practice.

Training providers

There was broad support for the learning outcomes in training providers' responses. They particularly approved of strengthening communication and collaboration skills in the learning outcomes, including collaboration with non-professional colleagues.

Training providers agreed with the principle of integration as, in their view, it provided a cohesive training programme that enables students' learning to be applied to practice. However, many training providers were unsure about how integration should be implemented (including in relation to coordinating interaction with several schools and reporting mechanisms on student's progress between the school, training provider and GPhC). They were also concerned about funding (including whether this might mean students losing the pre-registration salary, as well as the administrative infrastructures required, and training of supervisors) and explained that pharmacists involved in the supervision of students have to balance their teaching role with their clinical responsibilities. In their view, new appropriate and sustainable funding arrangements needed to be worked through and resolved prior to the implementation of any further changes.

Regarding admission requirements, training providers welcomed the assessment of applicants' skills and attributes and the inclusion of an interactive component in admission procedures. Communication skills and desire to care for patients were particularly important for them. Several training providers asked

how they could have an input in admission procedures as they felt they should be involved in those. There was common agreement in training providers' responses to no longer allow unconditional offers.

Overall training providers supported our proposal regarding experiential and inter-professional learning while asking how this would be organised.

Many training providers agreed with the proposal to replace the four tutor sign-offs by regular progress meetings and asked for more guidance on frequency of meetings structure, submitting documentation to schools of pharmacy and frameworks to oversee trainees. Several training providers asked how the signing-off of students' competence at the end of their initial educational and training would be organised between the schools and themselves. Training providers agreed with the proposal to replace the pre-registration performance standards with the learning outcomes but asked for guidance as to how the learning outcomes should be implemented.

Impact of the proposed changes

Patients and members of the public

Many respondents were of the view that our proposed changes would be beneficial for patients and members of the public as they would receive a higher standard of care.

Students

A common theme was that our proposed changes would be beneficial for the development of students and would increase the quality of the practice of future pharmacists.

The main concern of respondents focused on the financial impact of our proposals on students. Respondents were concerned that introducing an integrated degree would mean that students would have to pay for a fifth year of education and training and not receive a salary during their learning in practice. Respondents also anticipated that having several shorter learning in practice placements throughout the five years of initial education and training would mean additional accommodation and travel costs for students. Several respondents worried that international students who wish to obtain a UK MPharm degree, but not undertake their learning in practice in the UK, might decide against studying in the UK.

Schools of pharmacy

Schools of pharmacy were concerned about the resource and financial impact of our proposed changes. They explained that integration would require them to undertake significant transitions, which would be time and resource-intensive for them. They also anticipated increased costs to change and run their admission procedures; to secure, organise and quality assure experiential learning and learning in practice placements; to appoint and train staff; and to administratively manage programmes. They considered that in the current funding environment it would be hard for them to implement our proposed changes.

Training providers

Training providers were concerned about the logistics necessary to train students who were at different stages of their initial education and training, at different times and during shorter placements. They

were also unsure about how to work with several schools of pharmacy and worried about the impact of our proposed changes on the workflow of pharmacies. Training providers also mentioned the costs associated with training all staff involved in the supervision of students to a higher standard and increased administrative costs.

Training providers also explained that the current length of pre-registration placements enables them to train students to their processes and to assess students' competence before recruiting them. They were concerned that they would no longer be able to do this because of shorter periods of learning in practice.

Several training providers were also concerned that the introduction of shorter periods of learning in practice would mean that students would look for placements close to where they lived and that this would negatively impact training providers located in less populated and rural areas.

People sharing particular protected characteristics

We asked consultation respondents and stakeholders whether, in their opinion, our proposals may discriminate or benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. This section summarises respondents' views.

In regard to our selection and admission requirements, respondents mentioned potential impacts on mature applicants (positive impacts of assessing their skills and attributes; negative impacts of stricter academic requirements as they were more likely to have atypical qualifications), on young applicants (who might struggle to demonstrate they have the values, maturity and professional attitudes to become a pharmacist), on people with disabilities or communication issues (who might struggle to adapt to people's communication needs, to take into account non-verbal communication, or to demonstrate empathy), on Black, Asian and Minority Ethnic (BAME) groups (concern that the introduction of an interactive component in admission procedure would increase potential bias).

Regarding Integration, respondents mentioned potential impacts on mature students (cost of five years of initial education and training, caring responsibilities which make them less able to relocate for learning in practice), disabled people (difficulty to organise and relocate for several learning in practice placements).

Several respondents also explained that the support offered by training providers to people with disabilities was sometimes lacking and needed to improve.

Analysis of consultation responses and engagement activities: what we heard

1. Revising the learning outcomes

1.1. 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 last column in each table captures the views of all survey respondents ('Total N and %'). The responses of individuals and organisations are also shown separately to enable any trends to be identified.

Table 1: Views on the learning outcomes

Q1. Considering the full set of learning outcomes in Part 1 of the draft initial education and training standards, to what extent do you agree or disagree that these are appropriate learning outcomes for a pharmacist?	N and % individuals	N and % organisations	Total N and %
Strongly agree	163 (31%)	24 (24%)	**187 (30%)**
Tend to agree	270 (52%)	70 (69%)	**340 (55%)**
Neither agree or disagree	41 (8%)	3 (3%)	**44 (7%)**
Tend to disagree	20 (4%)	5 (5%)	**25 (4%)**
Strongly disagree	11 (2%)	0 (0%)	**11 (2%)**
Don't know	14 (3%)	0 (0%)	**14 (2%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

1.2. As reflected in the figures in Table 1 above, 85% of consultation respondents agreed with our proposed learning outcomes for the initial education and training of pharmacists, and 6% disagreed. Organisational respondents were more in favour of the learning outcomes (93%) than individual respondents (83%).

Table 2: Views on aspects missing or needing to be amended in the learning outcomes

Q2. Is there anything in the learning outcomes that is missing or should be changed?	N and % individuals	N and % organisations	Total N and %
Yes	130 (25%)	72 (71%)	**202 (33%)**
No	252 (49%)	28 (27%)	**280 (45%)**
Don't know	137 (26%)	2 (2%)	**139 (22%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

1.3. As can be seen from Table 2, just under half (45%) of consultation respondents were satisfied with the learning outcomes. A third (33%) of respondents thought that aspects were missing or needed to be amended in the learning outcomes. A larger proportion of organisational respondents felt the learning outcomes should be modified (71%) compared with 25% for individual respondents. However, a larger proportion of individuals felt that they did not know whether the outcomes needed to be modified (26%) compared to organisations (2%).

1.4. We asked the respondents who felt that aspects of the learning outcomes were missing and/or should be amended (responded 'Yes' to Question 2) which learning outcomes domains needed to be modified. Table 3 shows the number and percentage of respondents who identified each domain as needing additions and/or amendments.

Table 3: Views on the learning outcomes domains needing addition and/or amendments

Q3. Which of the following areas need additions and/or amendments?	Out of all individuals who responded 'Yes' to Q2 (N and %)	Out of all individuals Respondents (N and %)	Out of all organisa-tions who responded 'Yes' to Q2 (N and %)	Out of all organisa-tions respondents (N and %)	Out of all those who responded 'Yes' to Q2 (N and %)	Out of all respondents (N and %)
Person-centred care	42 (32%)	42 (8%)	43 (60%)	43 (42%)	85 (42%)	85 (14%)
Professionalism	47 (36%)	47 (9%)	41 (57%)	41 (40%)	88 (44%)	88 (14%)
Professional knowledge and skills	90 (69%)	90 (17%)	60 (83%)	60 (59%)	150 (74%)	150 (24%)
Collaboration	52 (40%)	52 (10%)	45 (63%)	45 (44%)	97 (48%)	97 (16%)
Other	31 (24%)	31 (6%)	17 (24%)	17 (17%)	48 (24%)	48 (8%)
Total N of responses	**130**	**519**	**72**	**102**	**202**	**621**

1.5. 74% of all respondents who responded 'Yes' to Question 2 felt that the domain on professional knowledge and skills needed to be amended. There were differences between individuals and

organisational responses. More organisational respondents felt that the domain on professional knowledge and skills needed to be amended (83% for organisations compared to 69% for individuals). However, the biggest difference in views between these two group of respondents focused on the domain on person-centred care (60% for organisations compared to 32% for individuals).

1.6. We asked the same respondents (those who responded 'Yes' to Question 2 – 33% of survey respondents) to give us a brief description of the additions and/or amendments they thought were needed. These survey respondents also made suggestions for clarification and ways in which the learning outcomes could be strengthened which are detailed in the commentary below.

1.7. Despite expressing the view that the learning outcomes required some modification, a significant number of these respondents expressed broad agreement on the learning outcomes. They welcomed the increased emphasis on people-centred care, clinical skills, and inter-professional working. Many respondents thought the learning outcomes were clear, ambitious, achievable and captured future pharmacists' practice. Several respondents were pleased that the number of learning outcomes, and so duplication, was reduced. More detailed feedback is given in the commentary below.

1.8. Stakeholders and patients and members of the public who took part in events and focus groups agreed with many of the views of survey respondents. They also provided additional areas for consideration in order to strengthen the learning outcomes. We have captured separate recommendations they made in this section.

General views

1.9. Many respondents agreed that the learning outcomes provided an accurate depiction of what a modern-day pharmacist should be capable of. Respondents felt that the learning outcomes would ensure that newly qualified pharmacists are competent and able to function in the workplace. Several respondents also welcomed the fact that the learning outcomes focus on key principles and are constructed in parallel with the Standards for pharmacy professionals.

Domain 1: Person-centred care

People-centred care and communication

1.10. There was strong support for the increased focus on person-centred care in the learning outcomes. A large number of the respondents who provided open-ended feedback agreed about the importance of empowering people in making decisions about their care. Patients and members of the public who participated in consultation events said there should be greater emphasis on empathy in the learning outcomes.

1.11. Many respondents welcomed the emphasis on communication skills. Patients and members of the public who participated in our engagement events, in particular, expressed that the listening skills and communication skills of some pharmacists currently practising could be improved. For them, pharmacists should ask the right questions and try to understand people's needs. In their view, pharmacists should listen, adapt to people's communication needs and take into account non-verbal communication. It was also mentioned in many consultation responses that pharmacists should make sure that people understand the information provided to them.

Considering people's needs rather than solely applying an evidence-based approach was a theme present in many consultation responses. Many respondents explained that pharmacists should be able to identify people's goals, discuss with people how medicines can contribute to achieve their goals and, to achieve that, they needed to have an understanding of the patient experience.

1.12. A common theme was that pharmacists should be trained to take into consideration cultural and religious differences, disabilities and sexual orientations. Respondents suggested that pharmacists should ask open and inclusive questions and use gender-neutral language. Some respondents proposed to teach the concept of equity to students. In their view, providing equitable services meant acknowledging the different and complex needs of people and adjusting care so that it is relevant to each person's healthcare needs. It was crucial for respondents that people receive healthcare relevant to their needs rather than based on assumptions made about them.

Domain 2: Professionalism

1.13. Patients and members of the public welcomed the learning outcomes that require students to learn to work within the limits of their competence and refer to other health and care professionals when necessary. There was also broad support for the learning outcomes focusing on continuous learning and self-development from both survey respondents and stakeholders.

1.14. Some respondents were of the view that the learning outcomes provided a clear definition of the term professionalism. In their experience, some students and supervisors struggled to understand its true meaning. Other respondents proposed for the learning outcomes to focus more on ethics. They explained that students could find making ethical decisions challenging.

1.15. A few responses pointed out that the distinction between Domain 2 (professionalism) and Domain 3 (professional knowledge and skills) was sometimes artificial as some learning outcomes could be placed in either domain. However, there was a more common agreement that learning outcome 2.13 on infection control would be better placed in Domain 3.

1.16. Several responses mentioned that the concept of resilience should be strengthened in Domain 2.

Domain 3: Professional knowledge and skills

Science

1.17. Many respondents were of the view that the learning outcomes were very practice-orientated. In their view, more learning outcomes needed to focus on pharmaceutical science. These respondents felt that the term "the science of pharmacy" was too broad and disagreed with scientific knowledge solely being captured in a single learning outcome. A number of respondents suggested the learning outcomes should refer to specific scientific domains. For them, this approach would ensure students acquire a solid scientific foundation enabling them to apply necessary scientific principles, solve problems and handle unexpected situations in their future practice. Several respondents provided specific examples of the scientific knowledge that should be mentioned in the learning outcomes. They mentioned antimicrobial resistance, polypharmacy and medicine reviews, immunology and biologicals.

1.18. Many responses highlighted that pharmacists are the only members of the healthcare team that have detailed scientific knowledge of medicines and that, for the benefits of patients, pharmacists should retain that expertise.

Clinical skills

1.19. There was broad support for the stronger emphasis on clinical skills in the learning outcomes. Many respondents agreed with the inclusion of learning outcomes on consultation, diagnostic and physical examination skills.

1.20. A large number of respondents were also in favour of our proposals to strengthen prescribing-related skills in the initial education and training of pharmacists. For them, incorporating pre-prescribing skills in the undergraduate degree would enable newly registered pharmacists to train as independent prescribers sooner. These respondents found clinical examination skills and diagnostic skills particularly useful.

1.21. Even though a significant number of respondents agreed about increased clinical skills in the learning outcomes, a few of them were concerned that it would be difficult to gain these skills in some training environments. They questioned how clinical skills should be delivered and met at the level 'Does' on the Miller triangle[1].

1.22. There was a small number of respondents who were concerned about physical examinations. They questioned whether a pharmacist would be expected to carry out a physical examination to the same standard than a doctor and worried about stretching pharmacists' responsibilities without appropriate training. A small number of respondents also queried whether there was a sufficient number of pharmacists with these skills to support students in developing these skills.

1.23. The respondents who disagreed with the increased focus on clinical skills explained that not all pharmacists would work in patient-facing roles. For them, pharmacists should remain the experts in the science of medicines. They were concerned that the basics of science would be diluted among other skills and that pharmacists would become generic clinicians. These respondents were in favour of learning outcomes with a stronger focus on the underlying science needed to inform people-centred care and collaboration.

Research activities

1.24. A small number of respondents questioned the importance of students engaging in research activities even if they agreed students should understand research, research techniques and how research is applied to practice. They proposed that students should be involved in clinical audit activities instead.

1.25. For other respondents, it was crucial for pharmacists to be taught to be critically reflective of their work and the work of others. In their view, a strong foundation in practice-based research would support the development of a profession which is thoughtful, sceptical and keen to evolve.

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Awareness and usage of technologies

1.26. Many respondents agreed with our proposal to introduce learning outcomes focusing on technologies.

1.27. Several responses underlined the need to focus on the use of data to improve care. They explained that the healthcare system is changing fast and that pharmacists play a more important role in public health and population level planning. Respondents proposed that more specific learning outcomes were needed to cover data, IT literacy and the use of electronic prescribing systems.

1.28. A few respondents also believed that technologies empowered pharmacists to conduct more meaningful diagnoses with favourable clinical outcomes and felt that digital diagnosis should become an integral part of pharmacy.

Domain 4: Collaboration

1.29. A few respondents were of the opinion that, because of its small number of learning outcomes and, in comparison to other domains, Domain 4 (collaboration) looked unbalanced.

Collaboration with other professions

1.30. There was broad support for the changes proposed which enable shared learning between professions and future pharmacists to work more closely with other health and care professionals. Respondents explained that pharmacists work as part of multi-professional teams in all care settings. For them, the ability to work well in teams was paramount to supporting the safe and effective management of medicines.

1.31. However, several respondents felt that MPharm degrees should emphasise that pharmacists work within and across sectors, but also that not all of pharmacists' interactions are with other health or social care professionals. In their view, students should also be prepared, for instance, to work with receptionists and for service managers and commissioners.

Leadership

1.32. Several responses welcomed the addition of clinical leadership in the learning outcomes. Event participants particularly approved of this addition.

1.33. A few respondents felt that the leading role pharmacists will have in future healthcare settings was not captured strongly enough in the learning outcomes. For them, leadership was especially important for pharmacists entering community pharmacy, as they may be expected to lead pharmacy teams from day one.

1.34. Other respondents, however, felt that expecting undergraduate students or newly registered pharmacists to demonstrate 'effective leadership' or 'clinical leadership' would be too much.

1.35. A small number of respondents asked for a definition of clinical leadership as they felt it could be interpreted differently by providers and students.

Level of the learning outcomes

1.36. Respondents had diverging views in regard to the level of the learning outcomes on the Miller triangle. A few respondents felt that all learning outcomes should be set at 'Does'. Others

proposed to change a few learning outcomes from 'Does' to 'Shows how', as it would be difficult for students to 'repeatedly and reliably' demonstrate their competence in some instances (for example learning outcomes focusing on safeguarding and on first aid).

1.37.   A few responses mentioned that the term 'understand' should not be used in the learning outcomes as it is too difficult to measure.

What is missing from the learning outcomes

1.38.   Several respondents were of the opinion that the MPharm degree currently does not appropriately cover management skills when many qualified pharmacists are expected to run a pharmacy and to manage staff and resources. They therefore suggested that the learning outcomes should cover management and organisational skills. In their view, pharmacists' training also needs to entail negotiating skills, people and project management skills.

1.39.   A small number of respondents pointed out that currently some pharmacists are uncomfortable when making decisions in areas of uncertainty. Others mentioned that some pharmacists do not always understand the need to work outside guidelines to prioritise patient safety. They felt these two elements needed to be covered in the learning outcomes.

1.40.   A few respondents mentioned that the learning outcomes only referred to the physical needs of patients. They were of the view that people's mental health needs should also be taken into consideration in the learning outcomes. They explained that currently many newly qualified pharmacists report feeling that their knowledge of mental health is not at the same level as their knowledge of physical health.

1.41.   A few responses also mentioned that other sectors in which pharmacists practise should be taken in consideration in the learning outcomes. For instance, they referred to industry and academia.

Implementing the learning outcomes

1.42.   Several respondents asked how and when the learning outcomes should be demonstrated and evaluated. Others asked for the GPhC to issue minimum expectations so that education and training providers know the level expected from students.

1.43.   Some respondents were concerned that the learning outcomes focussed on the five years of education and training. With several learning outcomes changing level from 'Shows how' to 'Does', several schools of pharmacy explained that the change in assessment techniques would require further financial investment.

1.44.   A number of respondents were also concerned that students who do not intend to practise as pharmacists or who do not want to complete their learning in practice in the UK might be negatively impacted by the fact that the learning outcomes were set for the five years of initial education and training. They were concerned these students would no longer consider studying pharmacy in the UK.

2. Revising the standards for providers

Table 4: Views on the standards for providers

Q4. Considering the full set of standards and criteria in Part 2, to what extent do you agree or disagree that these are appropriate for the initial education and training of pharmacists?	N and % individuals	N and % organisations	Total N and %
Strongly agree	147 (28%)	21 (21%)	**168 (27%)**
Tend to agree	258 (50%)	63 (62%)	**321 (52%)**
Neither agree or disagree	58 (11%)	4 (4%)	**62 (10%)**
Tend to disagree	27 (5%)	11 (11%)	**38 (6%)**
Strongly disagree	10 (2%)	0 (0%)	**10 (2%)**
Don't know	19 (4%)	3 (3%)	**22 (4%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

2.1. As reflected in the figures in Table 4 above, a majority of both individuals and organisations (79%) agreed that our proposed standards for providers were appropriate for the initial education and training of pharmacists. A slightly higher proportion of organisational respondents were in favour of the standards (83%) compared with individual respondents (78%).

Table 5: Views on aspects missing or needing to be amended in the standards for providers

Q5. Is there anything in the standards or criteria that is missing or should be changed?	N and % individuals	N and % organisations	Total N and %
Yes	97 (19%)	69 (68%)	**166 (27%)**
No	275 (53%)	20 (20%)	**295 (48%)**
Don't know	147 (28%)	13 (13%)	**160 (26%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

2.2. As can be seen from Table 5, 48% of respondents did not think anything was missing or needed to be changed from the standards for providers, whereas 27% felt that they needed to be amended. A much larger proportion of organisational respondents felt that aspects of the standards should be modified (68% compared with only 19% of individuals). A higher proportion of individuals felt that they did not know whether anything was missing or needed to be changed in the proposed standards (28%) compared with organisations (13%).

2.3. We asked the respondents who felt that aspects of the standards were missing and/or should be amended (responded 'Yes' to Question 5) which standards needed to be modified. Table 6 shows the number and percentage of respondents who identified each standard as needing additions and/or amendments.

Table 6: Views on the standards needing addition and/or amendments

Q6. Which of the following areas need additions and/or amendments?	Out of all individuals who responded 'Yes' to Q5 (N and %)	Out of all individuals respondents (N and %)	Out of all organisations who responded 'Yes' to Q5 (N and %)	Out of all organisations respondents (N and %)	Out of all those who responded 'Yes' to Q5 (N and %)	Out of all respondents (N and %)
Selection and admission	43 (44%)	43 (8%)	42 (61%)	42 (41%)	85 (51%)	85 (14%)
Equality, diversity and fairness	18 (19%)	18 (3%)	19 (28%)	19 (19%)	37 (22%)	37 (6%)
Resources and capacity	25 (26%)	25 (5%)	39 (57%)	39 (38%)	64 (39%)	64 (10%)
Managing, developing and evaluating initial education and training	25 (26%)	25 (5%)	27 (39%)	27 (26%)	52 (31%)	52 (8%)
Curriculum design and delivery	40 (41%)	40 (8%)	40 (58%)	40 (39%)	80 (48%)	80 (13%)
Assessment	31 (32%)	31 (6%)	28 (41%)	28 (27%)	59 (36%)	59 (10%)
Support and development for students and people delivering initial education and training	23 (24%)	23 (4%)	24 (35%)	24 (24%)	47 (28%)	47 (8%)
Learning in practice (pre-registration)	47 (48%)	47 (9%)	48 (70%)	48 (47%)	95 (57%)	95 (15%)
Learning in practice (pre-registration) supervision	42 (43%)	42 (8%)	37 (54%)	37 (36%)	79 (48%)	79 (13%)
Total N of responses	**130**	**519**	**72**	**102**	**202**	**621**

2.4. Respondents who responded 'Yes' to Question 5 felt that the domains on learning in practice supervision (57%), selection and admission (51%) and curriculum design and delivery (48%) needed to be amended. Respondents were least likely to say that that the domain on equality, diversity and fairness should be amended, with only 22% of respondents suggesting this.

2.5. There were also differences between individuals and organisational responses. More organisational than individual respondents felt that the domains on resources and capacity (57% compared to 26%) and on learning in practice (70% compared to 48%) should be modified.

2.6. We also asked the respondents who felt that aspects of the standards were missing and/or should be amended (responded 'Yes' to Question 5 – 27% of respondents) to give us a brief description of the additions and/or amendments they thought were needed. Their comments are detailed in the commentary below. The views of consultation event participants are also captured in this section as similar views were brought up.

2.7. The responses focusing on integration of study and practical learning and on selection and admission requirements have been analysed later in the report in the sections focusing on these topics (see sections 7, 8 and 9).

Equality, diversity and fairness

2.8. There was broad support for strengthening requirements in regard to equality, diversity and fairness. Many respondents welcomed schools having to carry out a review of student performance and admissions using the protected characteristics defined by the Equality Act 2010. A few respondents suggested specifically mentioning the protected characteristics, as defined in the Equality Act 2010. They were concerned that when referring to equality in general terms, certain protected characteristics might be forgotten or overlooked.

2.9. A small number of respondents proposed that education and training providers should seek students' feedback early on in the academic year or during the period of learning in practice to be able to act on it if needed. A few respondents also suggested that providers should proactively support the groups who are less successful in their education and training.

2.10. Pharmacists who mentioned having a disability explained that they received appropriate support while at university, but when they started their pre-registration placement their capacity had been questioned and they were not supported. Other respondents mentioned that training providers should be informed, in advance of learning in practice periods, of any reasonable adjustment students need.

Resources and capacity

2.11. A number of respondents were unsure about how to implement requirements on resources and capacity. Several of them asked what was an 'appropriate level of resource' to deliver a sustainable and accreditable initial education and training programme. A few others asked for clarifications on staff complement for the delivery of each component of the integrated period of initial education and training.

2.12. Some of the responses also focused on education and training premises. Several respondents asked who was responsible for determining premises are fit for purpose and how this should be measured. Many felt that some level of accreditation and standardisation would be necessary to ensure consistency across providers and countries.

2.13. A small number of respondents were of the opinion that a ratio of practising pharmacists to academic staff should be set to ensure the knowledge delivered in MPharm degrees is current and relevant to practice.

Managing, developing and evaluating initial education and training

2.14. A common theme among the responses on managing, developing and evaluating initial education and training, was for guidance to support implementation to ensure consistency across providers.

2.15. Several respondents asked for lines of responsibility to be explicitly detailed. Other respondents were of the opinion that quality assurance processes were needed nationally. They explained that training providers would be taking students from different years and at different times. In their view national mechanisms would ensure consistent quality of training.

2.16. Several responses focused on providers having to demonstrate how users' views are used to develop initial education and training. A few respondents believed that all stakeholders' views should be considered. Others felt strongly about taking into consideration current and previous student feedback. They agreed providers should be able to evidence how they collate and analyse student feedback and demonstrate how they address issues raised.

2.17. A few respondents pointed out that schools, in order to respect GDPR policies, did not keep data for a long period of time. They questioned how this would impact data requests from the GPhC.

Curriculum design and delivery

2.18. A significant number of responses focusing on curriculum and delivery also focused on how to implement our requirements. A few respondents requested clarification on simulated learning environments, number of assessment re-sits permitted, and delivering the learning outcomes in different settings.

2.19. There was broad agreement that as a general principle, all assessments must be passed.

2.20. When engaging with a range of stakeholders to develop a curriculum, a few respondents mentioned that care must be taken to ensure that a major stakeholder, such as an influential employer in a neighbourhood, does not unduly influence the content of the course.

Assessment

2.21. Taking into consideration the much-increased involvement of training providers in the initial education and training of pharmacists, respondents had many queries in relation to the assessment of students.

2.22. Respondents asked how training providers would assess students' competence, how students' assessment would be jointly led between education and training providers, how education and training providers would communicate on students' progression and who would be responsible for the final sign-off of students.

2.23. Other queries focused on the training of examiners and assessors, on liability in cases of errors, on the assessment of inter-professional training and on the range of assessment approaches that could be used.

Support and development for student pharmacists and people delivering initial education and training

2.24. A small number of respondents felt that it was important for students to have a pharmacist mentor at all times. However, others explained that current tutors are not always pharmacists. They welcomed the requirement for students to have access to pharmacy professionals who act as role models and mentors, but pointed out the small number of pharmacists in senior management positions in schools.

2.25. A few respondents asked how training providers would support staff in supervising roles. They requested guidance on induction and training materials for teams involved in delivering experiential learning and learning in practice.

Learning in practice

2.26. Many responses questioned how learning in practice should be implemented and what the responsibilities placed on stakeholders involved.

2.27. Some respondents asked for guidance regarding the number and length of learning in practice blocks. Others suggested translating the 52 weeks requirement into days, as more suitable for a model entailing shorter and more frequent placements. A small number of respondents were of the opinion that 52 weeks of learning in practice was not enough.

2.28. A large number of respondents proposed that learning in practice takes place in at least two sectors. Some respondents referred to the Welsh multi-sector pre-registration model and explained that students benefit more from a multi-sector approach. Others explained that a multi-sector approach would enable students to be exposed to a wider range of patients in a variety of environments and to learn how to deal with different kinds of patients with different, and at times complex, needs. Respondents generally agreed that through this approach students would gather a better understanding of the whole patient journey and of the roles of other health and care professionals. A few respondents made a more specific suggestion, asking that all students have at least one hospital experience, so that they understand a patient's journey through hospital.

2.29. Many responses focused on collaboration between education and training providers. A number of training providers were unsure about how they would accommodate the training of students from different schools and with different training needs. They felt that periods of learning in practice needed to be coordinated so they would not impact on workplace workflows. Many respondents (mainly education and training providers) proposed the creation of regional structures or frameworks to ease collaboration between stakeholders and ensure consistent quality. Several other respondents also asked about the quality assurance of learning in practice training locations. They wondered whether this would be carried out by schools or by the GPhC.

2.30. A small number of respondents were unclear about the distinction between learning in practice and experiential learning.

Learning in practice supervision

2.31. There were many requests for clarity and suggestions made regarding learning in practice supervision.

2.32. Respondents had diverging views on who should be able to supervise students. Some of them felt that designated learning in practice supervisors should only be pharmacists. Others explained that, as there is a strong emphasis on inter-professional learning in the standards, it would be appropriate for students to be supervised by other health and care professionals. They explained this would also increase the availability of placement opportunities for students.

2.33. A few respondents asked whether our training requirement of supervisors would apply to all supervisors, including other health and care professionals, or just to designated learning in practice supervisors.

2.34. Several respondents suggested that students' work-based experiences should be overseen by a school-based supervisor to ensure students meet the learning outcomes to the standard required. Others felt that schools should regularly check in with students to ensure the quality of their learning in practice progression.

2.35. There were also diverging views in regard to who should sign off students' competency and fitness to practise. Some respondents mentioned that schools signing off students could create a potential conflict of interest. They were concerned that schools might let some students graduate, even if they do not meet all the learning outcomes. Other respondents were of the view that designated learning in practice supervisors should not sign off students because of the relationship they build with them. These respondents thought that different individuals should mentor and assess students. Several other respondents felt that sign-offs should be jointly carried out by schools and supervisors and take place after each period of learning in practice.

2.36. Some respondents proposed that students have more than one pharmacist signing them off, or that they are signed off by independent assessors. Others made propositions for more robust and evidence-based mechanisms to evaluate students. They proposed progression reports and feedback from all individuals involved in a student's training to be collected, peer reviewed and assessed. In their view this would ensure that the quality of training is always maintained and enable a more holistic assessment of a student's preparedness for practice.

2.37. Several respondents mentioned that assuring the quality of learning in practice supervision was beyond the current ability and capacity of schools of pharmacy, unless additional funding was made available to enable them to recruit staff to supervise this aspect of the training.

Other feedback

2.38. A small number of respondents felt that certain positions in schools of pharmacy should be reserved to pharmacists. For instance, few respondents mentioned that heads of schools should only be pharmacists.

3. Integrating the five years of initial education and training

Table 7: General views on setting integrated standards for the five years of initial education and training

Q7. Do you agree or disagree that we should set integrated standards for the five years of education and training?	N and % individuals	N and % organisations	Total N and %
Strongly agree	244 (47%)	38 (37%)	**282 (45%)**
Tend to agree	155 (30%)	39 (38%)	**194 (31%)**
Neither agree or disagree	37 (7%)	8 (8%)	**45 (7%)**
Tend to disagree	27 (5%)	10 (10%)	**37 (6%)**
Strongly disagree	48 (9%)	5 (5%)	**53 (9%)**
Don't know	8 (2%)	2 (2%)	**10 (2%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

3.1. As reflected in the figures in Table 7 above, a majority of both individuals and organisations (77% and 75% respectively) supported our proposal to integrate academic and practice learning, and 15% of respondents disagreed with this proposal.

3.2. Just over two-thirds of respondents to the consultation survey provided open-ended comments to the consultation questions on integration. A significant number of these were supportive of integration, mentioning that integration would raise the standards of education and training and enable students to apply their knowledge in practice. This view was also frequently expressed during stakeholder meetings and events. However, many respondents were unsure about the implementation of this proposal, including the resources available to fund integrated programmes and expressed concerns about the potentially negative impact integration could have on students, schools of pharmacy and training providers.

Raising the quality of initial education and training and standardising students' experiences

3.3. There was broad agreement that integration would raise the quality of the initial education and training of pharmacists. Respondents were of the view that integration would enable students to progress faster, acquire a better skill set and become better pharmacists. They also welcomed students having a greater and earlier exposure to real-life practice. Respondents thought this would enable students to embody their roles, develop their communication skills, feel responsible and build their confidence earlier on, while undertaking clinical and patient-facing activities and collaborative work with health and care professionals. Several respondents also mentioned that integration would help students to develop professionalism at an early stage.

3.4. Several respondents pointed out the current variation in the quality of registered pharmacists' practice. In their view, integration would ensure a more consistent quality in students' learning/training and would raise the practice of pharmacists, enabling them to be better prepared for the workplace and be ready for their roles from day one. Many respondents also mentioned variations in terms of pre-registration experience. They welcomed the possibility of strengthening the quality assurance of placements and felt that integration would standardise workplace experience as schools would be able to train, support and assess tutors.

3.5. In general, respondents felt that integration would ensure a more coordinated and collaborative approach across providers and ensure that more cohesive training programmes are developed for students to meet the learning outcomes.

Application of knowledge in practice

3.6. From an educational perspective, many respondents explained that integration facilitates the consolidation of learning through earlier clinical application of underpinning knowledge in a live practice environment. For them, student pharmacists would gain more real-world experiences to contextualise their academic learning and be able to practically apply their learning in the context of health and care delivery.

Interaction with patients

3.7. Respondents agreed with our proposed changes in that pharmacists' training should be more people-centred and should entail early interactions with patients and members of the public. In their opinion, this would increase students' confidence, as this is something current students are sometimes lacking. Other respondents agreed that more practical experience should be incorporated into the MPharm degree as it is the practice element which enables students to move to the level of competency 'Does' on the Miller triangle.

3.8. A few survey respondents and stakeholder event participants pointed out that pharmacy is one of the only health and care professions where education and training are separate and independent from each other. They approved of aligning the structure of the initial education and training for pharmacists to the ones of other patient-facing professions.

Clear progression and better support for students

3.9. Several respondents appreciated being able to see the learning trajectory of student pharmacists over the five years of initial education and training. For them, integration would allow students a clear progression throughout the five years, from baseline to practice, and make sure students' learning is coherent, constructive and supported in all settings. Indeed, several respondents felt that student pharmacists' supervision would be improved as more than one tutor would support students. Several respondents mentioned that integration would enable schools and tutors to identify student pharmacists' strengths and weaknesses at an early stage and enable them to adequately support student pharmacists to develop.

3.10. Several respondents thought that integration will ease the current transition students experience when they start their pre-registration training. They explained that this transition can sometimes be daunting for students who don't have much contact with patients during the four years of their MPharm degree. A few respondents also mentioned that, thanks to the

earlier exposure to practice, students will be able to identify at a much earlier stage if they are not suited to the role of a pharmacist.

Support for the greater emphasis on clinical skills

3.11.   Many respondents mentioned that the roles and responsibilities of pharmacists have expanded, including increasing clinical responsibilities. For them, integration would enable future pharmacists to deliver much more clinical services and to be better prepared to meet the needs of the evolving healthcare landscape across the UK.

Financial and resource implications

3.12.   Even though many respondents were supportive of integration, many respondents were concerned about the financial impact of our proposal on students. They felt that this may mean that students would have to pay for a fifth year of education and training and gave the view that studentsshould still receive a salary or a bursary during their learning in practice. Several respondents also pointed out that students are likely to have increased travel and accommodation costs due to shorter learning in practice placements in different locations. They supposed that some students would choose training sites which are closer to where they live to reduce costs. Several respondents were concerned that an increased financial burden placed on students would reduce the number of people wanting to study pharmacy and make the MPharm degree less attractive.

3.13.   Schools were concerned about the costs and resource implications linked to the implementation of integration, the monitoring, supervision of tutors and the quality assurance of learning in practice. They explained that they don't currently have the capacity or resources to implement our proposal, as they would need to recruit staff and to change their administrative infrastructures.

3.14.   Several training providers also mentioned the need for additional resources to implement our proposals in the workplace. They expressed concerns about additional strains being placed on workplaces as staff will have to spend more time training and supervising students. Training providers also raised questions about how they would plan shorter placements throughout the year and co-ordinate the training needs of students from different schools. They anticipated that managing the training of several students with different development needs would be challenging.

3.15.   A common query was how integration would be funded with some respondents adding that current funding models provide real constraints. It was suggested that only substantial investment in pharmacists' education and training would enable a successful implementation of our proposal. Respondents were concerned about a reduction of training places if the necessary funding was not available and suggested that discussions with funding bodies should take place.

Concerns linked to learning in practice

3.16.   Several respondents were concerned about integration resulting in many short placements. In their experience, students need time to settle in the workplace before developing skills and too short placements could have a detrimental impact on their development. They preferred longer periods of practical learning to give students time to build confidence and to gradually increase

their responsibilities. A few other respondents were of the view that a longer placement at the end of the five years would ensure a better continuum from students to practitioners.

3.17. A small number of respondents were unsure about introducing placements too early as they felt students would not have the depth of academic learning to make full use of their placements. However, other respondents believed that in order to meet the future workforce and population health needs, all MPharm degrees should plan clinical exposure from day one, to allow students to be upskilled at an earlier stage.

3.18. There were a few concerns that changing the status of trainees, from employees to students, would have a negative impact on students' attitude or mindset during their learning in practice. A small number of respondents suggested that students might become less responsible because they would have less exposure to regular working routines and may not be paid for their work.

3.19. The majority of the respondents who disagreed with our proposal thought that the 4+1 model should be kept and many suggested that only experiential learning and pre-registration requirements should be strengthened, as well as their quality assurance. A few respondents were concerned that if a model akin to the current 4+1 MPharm degree remained (i.e. a 5-year programme with a significant final year placement), then the pressure to achieve the five-year learning outcomes would still be within the final twelve months. They felt that the GPhC should clearly state which learning outcomes should be achieved before the 'break point' of 4 years (before the final clinical placement).

3.20. Some respondents were opposed to our proposal because they did not think integration would raise the quality of the initial education and training of pharmacists and harmonise students' experiences. Other respondents were opposed to the greater focus on clinical skills. They explained that not all students will become pharmacists in the NHS or work with patients. In their view, the integration of academic and practical learning would make the MPharm degree less attractive for these students, as well as for international students wishing to study in the UK and complete their practical training overseas.

4. Selection and admission requirements

Table 8: Views on assessing the skills and attributes of prospective students as part of their admission procedures

Q8. Do you agree or disagree with our proposal to require schools of pharmacy to assess the skills and attributes of prospective students as part of their admission procedures?	N and % individuals	N and % organisations	Total N and %
Strongly agree	289 (56%)	58 (57%)	**347 (56%)**
Tend to agree	137 (26%)	30 (29%)	**167 (27%)**
Neither agree or disagree	36 (7%)	5 (5%)	**41 (7%)**
Tend to disagree	29 (6%)	3 (3%)	**32 (5%)**
Strongly disagree	22 (4%)	4 (4%)	**26 (4%)**
Don't know	6 (1%)	2 (2%)	**8 (1%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

4.1. As reflected in the table above, 83% of consultation respondents were in favour of assessing the skills and attributes of prospective students. The views of individual and organisational respondents were similar (82% and 86%). 9% of consultation respondents disagreed with that proposal.

4.2. Just over half of respondents provided open-ended feedback to this question. Overall they agreed with a more holistic assessment of applicants' potential to ensure students successfully register with the GPhC. They discussed the skills and attributes that should be considered and agreed on the importance of admission procedures being inclusive. The views of event participants were similar to the ones of survey respondents and are also captured in this section.

Assessing the skills and attributes of prospective students

4.3. There was broad support for taking into consideration more than the academic capabilities of applicants during admission procedures. Respondents explained that the more academically accomplished students do not always make the best pharmacists. Many respondents also mentioned that solely considering applicants' qualifications does not provide a sufficient picture of an applicant's readiness to study on an MPharm degree.

4.4. Other respondents agreed with the assessment of applicants' suitability to work as a pharmacist because they thought that currently some students can lack communication skills, empathy or do not always have the passion and drive to study pharmacy. Many respondents were of the opinion that personal values and behaviours are developed prior to university. These respondents agreed that assessing the skills and attributes of prospective students would strengthen the quality of pharmacy students admitted onto MPharm degrees. For them, only

students possessing the personal and professional values required to deliver person-centred care and to collaborate with others should be granted entry onto MPharm degrees.

4.5. A large number of respondents agreed with the proposals to assess the skills and attributes on admission as they felt that only the right applicants should be accepted onto an MPharm degree, even if this means a smaller overall number of students. In their view, the assessment of an applicant's ability to attain the level expected from the profession needs to be rigorous to help standardise the baseline attributes of students recruited into the profession. It was pointed out that the role of pharmacists has evolved significantly in response to different pressures and it was normal for the profile of students to align to these changes. Other respondents were of the view that schools currently accept too many students, even when some of them would not be able to graduate.

4.6. Some respondents expressed that it was unfair to give students a place on an MPharm degree if they were unlikely to meet the standards required to register or in pharmacists who lack the ability to deliver compassionate care to patients. They were of the view that admission procedures should have the objective to identify the applicants who would be able to successfully graduate and become pharmacists. In their view, this would only be possible if the skills and attributes of applicants are taken into consideration in admission procedures. Respondents agreed that a more robust admissions procedure, which better reflects the requirements of the course, would reduce the number of students retaking years of study, failing to complete the course, as well as potential issues arising during or after registration.

Skills and attributes which should be assessed

4.7. When mentioning the skills and attributes that they thought should be assessed in applicants, many respondents underlined the importance of communication, interpersonal skills and social awareness. For them, it was imperative that pharmacists are able to explain their knowledge to patients and to communicate effectively with people from all backgrounds. Respondents also agreed that pharmacists need to be able to engage with multi-disciplinary teams. They explained that inter-professional working is much more prevalent in the workplace today and that students should be adequately prepared for it. Several respondents proposed the written and spoken English of applicants (international and home applicants) should be assessed, as they thought their communication was sometimes problematic.

4.8. There was broad agreement about considering the motivation of applicants to study on an MPharm degree or to become a pharmacist. Some respondents felt that too many applicants who do not know what a pharmacist does or have little interest in becoming a pharmacist are currently admitted onto MPharm degrees. They were particularly concerned about applicants who see an MPharm degree as a 'plan B' to medicine and dentistry.

4.9. Many respondents also felt that applicants should be interested in working with patients. Several pre-registration tutors explained that some of the trainees they supervised were lacking a people-centred approach. In their view, most pharmacists will operate in patient-facing roles and it was essential to ensure applicants are interested in working with people. Respondents explained that pharmacists need to be compassionate, caring, empathetic and able to emotionally connect with people.

4.10. Some respondents proposed the assessment of numeracy skills of applicants, while others suggested having mechanisms to ensure that applicants are sufficiently mentally and emotionally resilient to work in the profession.

Ensuring admission procedures are inclusive

4.11. In general, respondents agreed that admission procedures need to balance a high standard of admissions with ensuring widened opportunities. There was broad agreement that the assessment of applicants should ensure that no group is disadvantaged by admission procedures.

4.12. Some respondents felt that assessing the skills and attributes of applicants would mean that applicants with prior experience of the pharmacy sector would be appropriately considered.

Concerns about assessing the skills and attributes of applicants

4.13. A number of respondents were concerned that it was difficult to ascertain accurately a person's set of skills, attributes and values at the point of entry to a degree at the age of 17/18 and that schools' admission procedures should be mindful that some concepts, such as professionalism or patient-centred care, are potentially more "difficult" for some applicants.

4.14. Many respondents also pointed out that students mature considerably between the ages of 17 and 22. They explained that students' social and interpersonal skills develop significantly throughout their studies. For them, some skills can be learned. These respondents therefore did not think that assessing all skills and attributes required of a registered pharmacist at admission was appropriate. They felt that admission procedures should be designed to accept onto MPharm degrees the candidates who have the potential to develop into person-focused and caring pharmacy professionals. A small number of respondents wondered which skills and attributes could be tested by admission procedures and which ones could be developed over the course of initial education and training. They welcomed clarity on the matter.

4.15. Some respondents felt that because applicants were too young and might not be able to demonstrate the maturity and professional attitudes required of them, assessing applicants' skills and attributes would not provide a good measure of their future abilities and were concerned that too stringent admission procedures would prevent applicants who could become successful pharmacists from entering onto MPharm degrees.

4.16. A small number of respondents were also concerned that assessing applicants' skills and attributes would dissuade applicants as school leavers would choose to apply to other healthcare professions.

4.17. Several respondents pointed out that not every MPharm student will work in a patient-facing role, or become a practising pharmacist. They explained that some students may choose to work in industry or academia. These respondents questioned the need to assess the communication skills of applicants and did not want the selection process to eliminate applicants more suited to research for example.

Table 9: Views on making an interactive component mandatory in admission procedures

Q9. Do you agree or disagree with our proposal to make an interactive component mandatory in integrated initial education and training admission procedures?	N and % individuals	N and % organisations	Total N and %
Strongly agree	250 (48%)	59 (58%)	**309 (50%)**
Tend to agree	159 (31%)	25 (25%)	**184 (30%)**
Neither agree or disagree	43 (8%)	9 (9%)	**52 (8%)**
Tend to disagree	28 (5%)	6 (6%)	**34 (5%)**
Strongly disagree	25 (4%)	1 (<1%)	**26 (4%)**
Don't know	14 (3%)	2 (2%)	**16 (3%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

4.18.   As the above table indicates, 80% of consultation respondents agreed with our proposal to make an interactive component mandatory in admission requirements. The views of individual and organisational respondents were similar (79% and 83%). 9% of consultation respondents disagreed with that proposal.

4.19.   Just under half of respondents provided open-ended comments to this question. Many respondents explained why interactive components should be incorporated in admission procedures, others made specific suggestions regarding their format. Several respondents also considered how interactive components could remain inclusive, while others mentioned the cost linked to the introduction of this proposal. The views of stakeholders, patients and members of the public who participated in our events is also represented in this section, as these were similar to the ones of survey respondents.

Informing applicants of what a career in pharmacy means

4.20.   There was common agreement that admission procedures should also inform applicants about what pharmacy practice entails so they know what to expect from the profession. Some respondents explained, that in some cases, trainees only realise during their pre-registration placement that pharmacy is 'not something for them'. In their opinion, providing applicants with that information during admission procedures would enable them to choose the right course for them.

Advantages of having interactive components in admission procedures

4.21.   There was general agreement that including interactive components in admission procedures would ensure a better assessment of applicants as respondents felt that conducting interviews was essential to assessing applicants' skills and attributes.

4.22. There was a common theme about the importance of assessing applicants holistically and not just on their academic performance. Other respondents mentioned that written applications do not always truly reflect an applicant's personality, values, skills and attributes. Many respondents who provided open-ended feedback agreed about the limitations of an admission process requiring applicants to describe their skills instead of demonstrating them. For them, skills and attributes can only be assessed through interviews, meetings, group activities or discussions.

4.23. Many respondents felt that the only way to assess the communication and personal skills of applicants was through an interactive assessment. Many also felt that interviews were an excellent mean of assessing the motivation of prospective students.

Assessment format

4.24. Many respondents commented on how applicants should be assessed. A large number of them were in favour of a collaborative approach. They proposed that schools should involve employers from all sectors of pharmacy, learning in practice supervisors, pharmacists, patients, carer groups and lay people in admission procedures. In their view, a joined-up approach would ensure that a full spectrum of views on an individual's suitability for patient-facing practice is sought.

4.25. Several respondents made specific suggestions. They felt that admission procedures should take place in multiple settings, include a panel interview, group interviews, multi mini interviews (MMIs), a UK clinical aptitude test (UKCAT). A few respondents proposed to take the Biomedical admission test (BMAT) as an example.

4.26. Respondents were divided in regard to conducting face-to-face interviews. A small number of respondents did not think that conducting interviews over Skype was appropriate. They felt that some skills and attributes, for instance empathy, could only be assessed face-to-face. These respondents proposed that all applicants residing in the UK were interviewed face to face, even if they applied through Clearing. Schools, however, explained that there was little to no time to organise face to face interviews during Clearing. They proposed to conduct interviews using digital technologies or on the phone during that period. Some individual respondents and organisations also thought that one-to-one interviews over video were acceptable but, in their view, these should be justified by individual circumstances and should not become the norm.

4.27. A small number of respondents suggested that schools should consider remote selection centres as this would support equity of assessment and access. In general, respondents agreed there must be equitable mechanisms for selecting candidates irrespective of their route of entry. Ensuring consistency and equity were common themes across many consultation responses. It was also mentioned that admission procedures should be comparable across all schools and during Clearing in order to maintain high standards.

Ensuring admission procedures are inclusive

4.28. A large number of respondents were concerned that making an interactive component in admission procedures mandatory would disadvantage school leavers from less privileged backgrounds, from lower-performing schools or colleges, or sharing particular protected characteristics. Their main concern was that these school leavers might not have had the social and educational opportunities to develop their self-confidence, communication skills and group

work and therefore would perform less well during an interactive assessment. Respondents expected schools to ensure that students from disadvantaged backgrounds are not overlooked because of inadequate support in preparing for the admission process. Some respondents questioned how shy individuals or applicants with social anxieties would be impacted by this proposal. Other respondents mentioned that some applicants from wealthy backgrounds can be coached for selection interviews which would play in their favour and felt this needed to be taken into consideration.

4.29.   Some respondents also mentioned that interactive assessments, such as situational judgement tests and multiple mini interviews, could introduce further subjectivity and unconscious bias in admission procedures. They felt that strong safeguards against unconscious and conscious bias should be put in place to ensure the fairness and reliability of such processes. In that regard, many respondents welcomed the proposal for providers to analyse the admissions profile of applicants by protected characteristics. Others underlined the importance of adequate training for everyone involved in admission procedures.

4.30.   A small number of respondents suggested that interactive assessments might enable applicants who failed to obtain required grades to be considered and show through their skills and motivation that they are worthy to be accepted onto an MPharm degree.

4.31.   A small number of respondents mentioned that applicants did not all have the same access to technologies such as the internet. They suggested removing the references to specific technologies so as not to negatively impact any applicants.

Financial and resource implications

4.32.   Many schools mentioned the cost linked to incorporating an interactive component into their admission procedures. In particular, they mentioned: the large number of applicants; the training they would have to deliver to their staff; the fact that some candidates apply outside the standard recruitment period (Clearing, international applicants); and that some interview strategies are resource-intensive. These respondents suggested schools would struggle to deliver this proposal without additional funding.

Table 10: Views on being more prescriptive about admission requirements

Q10. To achieve this balance, should we be more prescriptive about admissions requirements?[2]	N and % individuals	N and % organisations	Total N and %
Yes	301 (58%)	48 (47%)	**349 (56%)**
No	141 (27%)	30 (29%)	**171 (28%)**
Don't know	77 (15%)	24 (24%)	**101 (16%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

4.33.   As Table 10 indicates, 56% of respondents felt that we should be more prescriptive about entry requirements. A larger proportion of individual respondents (58%) were in favour of more

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[2] **Consultation on initial education and training standards for pharmacists** (pages 39 and 40)

prescriptive entry requirements compared to organisational respondents (47%). A higher proportion of organisations were unsure whether we should be more prescriptive (24%) compared with individuals (14%).

4.34. Almost two-thirds of respondents provided open-ended feedback to this proposal. Respondents had diverging views on setting more prescriptive admission requirements. Some respondents felt that minimum entry requirements should be set to ensure high standards are maintained and to be fairer to students. Other respondents felt that entry requirements should be left to schools and that some flexibility regarding required entry grades should be allowed. Many respondents also repeated their support for inclusive admission procedures. The views of consultation respondents also reflect what was heard in our stakeholder events, although fairness to applicants was particularly important to patients and members of the public.

Setting more prescriptive admission requirements

4.35. A common theme amongst respondents who provided open-ended comments was that more prescriptive admission requirements would maintain high academic standards and ensure the best applicants are selected. Many respondents underlined the difficulty of the MPharm degree, the high expectations placed on the profession and the fact that the NHS is planning to give pharmacists a leading role in the future. In their view, admission procedures should ensure the selection of students who would be able to meet these expectations.

4.36. A large number of respondents were of the view that only prescriptive admission requirements would reduce the number of students who are not able to complete the MPharm degree, their pre-registration placement or to pass the registration assessment. They felt that a more rigorous selection of applicants would be fairer to the students who are likely to struggle to meet the course's expectations and would fail to register as a pharmacist. They explained that students invest considerable resource and time in their education and training and accepting applicants with lower grades than the required grades would potentially disadvantage them from the outset.

4.37. Several respondents proposed that we should set minimum entry grades (in general or for specific scientific subjects) to ensure consistency between the different schools. In their view, the differing standards of the schools in regard to entry requirements were of concern and only applicants meeting the academic criteria should be accepted. Patients and members of the public considered that more consistency would reinforce public confidence in the aptitude and proficiency of new pharmacists. A small number of respondents also mentioned the performance pressures universities are under and felt that in that climate, it was important for us to set specific minimum requirements. The respondents who asked for minimum entry grades encouraged us to engage with schools to ascertain what admission requirements were appropriate.

4.38. Some respondents were of the opinion that schools should not be allowed to admit onto their MPharm degrees applicants who did not meet their academic entry requirements to ensure the integrity of the profession. Other respondents felt that a degree of flexibility could be allowed and that schools could accept a small number of applicants who did not meet their entry grades. However, in their view, schools should be held accountable and, when accepting applicants with low academic achievement, explain their decisions.

4.39. Other suggestions included the GPhC specifying which A-level subjects should be considered by schools and specifying a maximum percentage of places allocated to applicants with lower grades.

4.40. A few respondents were concerned about the number of applicants getting into pharmacy through Clearing. They proposed that only applicants who met the required grades should be accepted onto MPharm degrees, or to limit their number (for example set percentage for each school).

Not only focusing on academic requirements

4.41. A large number of respondents explained that some school leavers do not achieve the minimum entry requirements but still have the academic ability, skills and attitudes to make good pharmacists. It was therefore for them that admission procedures do not only focus on applicants' grades. According to them, assessing an applicant's potential, personality, attitude to learning, attention to detail, communication skills, and empathy was as important. In their view, pharmacy was much more than academic excellence and only taking into consideration academic achievement was misguided.

4.42. Other respondents suggested that, schools should be given the flexibility to make judgements, taking into account applicants' personal and social circumstances, as well as their skills and attributes, in cases where they have missed the entry requirements by a few grades. These respondents felt that, as long as there were clear documented reasons for accepting students who did not meet the academic criteria, schools should be able to accept them.

GPhC involvement in admission requirements

4.43. Other respondents, mainly schools of pharmacy, were of the opinion that entry requirements (including the possibility to accept unconditional offers) should be left to schools. In their view, the regulator should only provide guidelines and allow schools to set their own admissions standards as much as possible. They explained that schools have quality assurance procedures that prevent students who are unable to progress from moving one year to the next. These respondents were also of the view that the emphasis should be placed on developing academic performance and supporting students to achieve their potential. For them, admission procedures should not prevent the admission of students who, with support, may be able to complete the programme. Several respondents explained that this approach was especially important for applicants with historically low participation in higher education.

4.44. A number of respondents mentioned that each school has its own approach to teaching and that students flourish in different environments. In their opinion, some schools were better than others in supporting students who have entered with lower grades. They therefore argued that entry requirements should not be the same for all schools and proposed that schools track the performance of their MPharm students according to their entrance qualifications and grades and to review their admission criteria based on that evidence.

4.45. Several respondents were concerned that more prescriptive admission requirements would lead to some schools not being able to recruit to their target numbers and having to close. They explained that admissions criteria vary depending on supply and demand and that more restrictive requirements would interfere with the functioning of this market.

4.46. A small number of respondents were concerned that setting more prescriptive entry requirements would prevent schools from accepting applicants with equivalent qualifications (for example foundation degrees, access diploma and overseas qualifications) or relevant experience (for example pharmacy technicians, mature students).

Evidence base supporting the proposed changes

4.47. Several schools asked what evidence base was used in drafting the consultation proposals in relation to admissions. Some questioned the fact that solely assessing the past academic achievements of applicants was not sufficient in predicting students' future academic success. Others asked about the registration assessment success rate of students who entered the MPharm degree via Clearing or had been made an unconditional offer. These respondents felt that a careful analysis focusing on the link between admissions and registration assessment success should be undertaken. They believed this research should be undertaken before setting more prescriptive requirements.

Ensuring admission procedures are inclusive

4.48. There was a common theme about the importance of ensuring a balance between maintaining high admission standards and widening access. For them, allowing school leavers into the profession who previously may not have considered becoming a pharmacist, would enhance the attributes of the profession.

4.49. Many respondents were concerned that school leavers from lower socio-economic backgrounds, who may not have realised their full potential at A-levels, would be negatively impacted by stricter requirements. For them, it was important for schools to be able to make exceptions or apply alternative standards to applicants based on schooling, background or other circumstances. Respondents suggested that the groups of people who would fall into these categories should be identified and distinguished from applicants who are clearly unsuitable for the course. For example, they proposed slightly lower academic criteria to be applied to the candidates scoring particularly well in the interactive components of admission procedures.

Table 11: Views on disallowing unconditional offers

Q11. Should we continue to allow unconditional offers?	N and % individuals	N and % organisations	Total N and %
Yes	113 (22%)	17 (17%)	**130 (21%)**
No	334 (64%)	59 (58%)	**393 (63%)**
Don't know	72 (14%)	26 (25%)	**98 (16%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

4.50. Table 11 shows that 63% of consultation respondents were of the opinion that unconditional offers should not be allowed. The proportion of individual respondents who felt that unconditional offers should not be allowed (64%) was marginally larger compared to that of

organisational respondents (58%). A higher proportion of organisations were unsure whether we should continue to allow unconditional offers (25%) compared with individuals (14%).

4.51. Just over half of survey respondents provided open-ended feedback to this question. Many of these respondents felt that unconditional offers should not be allowed – a position shared by the patients and members of the public who participated in consultation events. Others were in favour of a more flexible approach.

Views on unconditional offers

4.52. Respondents made a distinction between different types of unconditional offers. Most of them felt that offering unconditional offers to students, who met entry requirements, but deferred joining the programme (for example because of a gap year) was appropriate. Scottish respondents explained that, in Scotland, unconditional offers are made only after attainment of the desired grades.

4.53. There was broad agreement that unconditional offers were not appropriate for a professional degree as many respondents thought that unconditional offers undermined public confidence in pharmacists and sent the wrong message to the profession. They expected practising pharmacists to meet high standards at all times and to commit to life-long learning. For them, these two elements should be mirrored in admission procedures and applicants should be able to demonstrate they maintained a high work ethic throughout their school years. Many respondents thought that unconditional offers did not encourage excellence and were detrimental to raising the standards of education and training.

4.54. Several respondents were of the view that MPharm places should be awarded on merit, and not on predicted achievement. They did not want pupils to lose the incentive to prepare for their A-levels and not study to their academic ability. Several respondents felt that the inadequate preparation of pupils for their A-levels might lead to school leavers not being adequately prepared for an intensive university course as such as the MPharm degree. For them, the A-levels were not an end in themselves but provide the knowledge needed for the pharmacy course.

4.55. Other respondents considered that unconditional offers were not transparent or fair to other students who worked hard for their A-Levels.

4.56. A few respondents pointed out that introducing an interactive component in admission procedures would be incompatible with allowing unconditional offers, when they are granted without interviews.

Flexibility with grades

4.57. Other respondents, mainly schools of pharmacy and a few individual respondents, thought that some flexibility in regard to academic achievements required for entry onto an MPharm degree should be allowed. In their opinion, some applicants still have the capacity to complete an MPharm degree even if they missed the required grades by a few marks. Suggestions included: comparing applicants' academic results to other entry requirements, applicants' motivation and aptitude to learn, and taking into consideration the personal circumstances that might have led to poorer academic performance.

4.58. A few patients and members of the public suggested allowing unconditional offers while controlling their number. They suggested setting a maximum percentage for all schools.

5. Experiential learning and inter-professional learning

Table 12: Views on our proposals in regard to experiential learning and inter-professional learning

Q12. Do you agree or disagree with our proposals in regard to:	Experiential learning (practical learning)? N and % individuals	Experiential learning (practical learning)? N and % organisations	Experiential learning (practical learning)? Total N and %	Inter-professional learning? N and % individuals	Inter-professional learning? N and % organisations	Inter-professional learning? Total N and %
Strongly agree	297 (57%)	59 (58%)	**356 (57%)**	290 (56%)	57 (56%)	**347 (56%)**
Tend to agree	149 (29%)	32 (31%)	**181 (29%)**	159 (31%)	32 (31%)	**191 (31%)**
Neither agree or disagree	31 (6%)	3 (3%)	**34 (5%)**	31 (6%)	2 (2%)	**33 (5%)**
Tend to disagree	18 (3%)	4 (4%)	**22 (4%)**	17 (3%)	7 (7%)	**24 (4%)**
Strongly disagree	13 (3%)	2 (2%)	**15 (2%)**	13 (3%)	2 (2%)	**15 (2%)**
Don't know	11 (2%)	2 (2%)	**13 (2%)**	9 (2%)	2 (2%)	**11 (2%)**
Total N of responses	519 (100%)	102 (100%)	621 (100%)	519 (100%)	102 (100%)	621 (100%)

5.1. As reflected in the figures in Table 12 above, 86% and 87% of consultation respondents agreed with our proposals in regard to experiential learning and inter-professional learning respectively. The views of individual and organisational respondents were similar (86% and 89%). 6% of all consultation respondents disagreed with each of the proposals.

5.2. Just over half of consultation respondents provided open-ended feedback to these proposals. A large number of them welcomed our proposed changes, with many mentioning the current variations in the delivery of these two components. Some respondents made suggestions in regard to implementing our proposed changes.

Benefits of experiential learning and inter-professional learning

5.3. There was general approval for an increase of experiential and inter-professional learning as this would enable students to improve the standards of practice of pharmacists.

5.4. There was broad agreement that, as the pharmacist role becomes more clinical, it was important that students are exposed to patients and real-life situations as early in their training as possible. Many respondents felt that pharmacists needed to have experience of working with patients before going into practice, to be able to better communicate with them and to improve their consultation and diagnostic skills.

5.5. Many respondents were of the view that more experiential learning would better prepare students for the workplace environment. They felt that experiential learning was essential for students, so they are able to: translate theory into practice, understand their role and own limitations, build up their confidence and be better prepared to interact with patients and colleagues.

5.6. A large number of respondents also explained that pharmacists are increasingly working as part of multi-disciplinary teams. Respondents felt that increased communication skills would enable pharmacists to practice to a high clinical level and as part of clinical teams. For many respondents, inter-professional learning should be incorporated in MPharm degrees from the start so that students can forge working partnerships and awareness of roles and responsibilities at the earliest possible stage.

5.7. Several schools mentioned they were already offering more experiential and inter-professional learning in their programmes and that students found these two components beneficial.

Current variation in delivery

5.8. Some respondents felt that our proposals in regard to experiential learning should go further. They were of the opinion that the amount of experiential learning should be standardised. Training providers especially explained that they had noticed some important differences in pre-registration trainees' competences depending on how much experiential learning their MPharm degree entailed. In their experience, students who had benefited from more experiential learning tended to be able to 'get on' with their pre-registration placement much more easily. Other respondents observed that, currently, students had limited direct and simulated patient exposure. For instance, several pharmacists explained that they did not properly carry out a consultation or a drug history with a 'real' patient before their pre-registration training. Several respondents pointed out that other healthcare students spent much more time in the workplace than student pharmacists.

5.9. Similarly, many respondents explained that, as inter-professional learning was not formalised, there was a lot of variation in the delivery of inter-professional learning. A large number of respondents mentioned that some students do not get to meet with other health and care professionals, and this results in students not always being confident when interacting with colleagues. They felt it was essential to embed inter-professional learning best practice throughout the five years of initial education and training to ensure more consistency between providers and that all students are appropriately prepared for their future practice. For them, increasing exposure to other professional groups and introducing multi-sector training much earlier in the MPharm degree would build students' resilience to challenging transitions.

Learning needs

5.10. Many respondents agreed that students needed insight into the different roles of pharmacists from the start of their training, so they are later able to relate to patients and provide high

quality care. They suggested that students should be exposed to a range of patients in a variety of environments, so they learn how to deal with different kinds of patients with different, and at times complex, needs. It was important to some respondents that students developed their communication skills in a wide variety of real-life situations and not just in simulated settings.

5.11. Many respondents felt that inter-professional learning would enable students to learn how to interact with different health and care professionals to be able to deliver higher standards of care and to work as an active member of the multi-disciplinary team. There was broad agreement that pharmacists needed to know how their role fits in the multi-disciplinary team and to understand the strengths and limitations of other professions. Several respondents pointed out that inter-professional learning would also enable other professions to better understand the role of pharmacists, which would be beneficial for building stronger working relationships with them in the future.

Delivering experiential learning

5.12. Many respondents made specific suggestions or required clarifications on how to implement experiential learning and inter-professional learning.

Experiential learning

5.13. Several respondents were of the opinion that experiential learning should be introduced in MPharm degrees from day one, that activities should be meaningful, and that students should be appropriately supported. Respondents emphasised that students should not only observe but also participate at a level which was appropriate to their competency.

5.14. Other respondents asked for minimum acceptable requirements. They wondered what was the minimum amount of experiential learning that should be incorporated in MPharm degrees. It was, in their view, important to set a minimum requirement to ensure consistency between schools.

5.15. A small number of respondents thought that students should have a minimum amount of clinical knowledge before being exposed to certain situations. For them, experiential learning should take place at a point which was both clinically appropriate and safe for students to have interactions with patients and other healthcare professionals.

5.16. Several respondents suggested that schools should work with training providers to ensure sessions are tailored to students' learning needs. They favoured a collaborative approach to develop models which would work for all parties and across multiple sectors.

5.17. A few respondents felt that students should be exposed to several sectors of pharmacy practice and rotate between hospital, community, GP settings, laboratory, industry settings, etc. A small number of respondents indicated that students should also have contact with non-clinical individuals working in healthcare (for example service managers and commissioners).

Inter-professional learning

5.18. Respondents, mainly schools, required more clarification on the amount and frequency of inter-professional learning.

5.19. There was a number of specific suggestions in regard to how inter-professional learning should be delivered. Several respondents felt that it should be mandatory, and similarly to experiential

learning start as early as the first year of the MPharm degree, should take place in a few different training sites and regularly throughout all stages of the education and training pathway. Other respondents were of the view not to limit students' exposure to dentists, nurses and doctors.

5.20. As for experiential learning, some respondents wanted the regulator to set a minimum requirement for inter-professional learning. However, others pointed out that the quality of inter-professional learning was more important than its frequency.

5.21. There were also a few requests for guidance on how schools and training providers should work together. Respondents were unsure about how schools should monitor inter-professional learning and ensure the quality of assessment in different placement sites.

Challenges linked to the delivery of our proposals

5.22. Many responses underlined the potential cost of our proposals. Schools explained that they would need further funding to be able to successfully implement both experiential and inter-professional learning. They also pointed out significant resource and logistic costs.

5.23. In regard to experiential learning, respondents explained that shorter and more frequent placements would need to be coordinated alongside longer periods of learning in practice. Schools explained that any increases beyond current provisions would require more funding. They anticipated they would need to recruit staff, involve expert patients and increase their administrative resources.

5.24. In regard to inter-professional learning, respondents mentioned that, contrary to other professions, additional funding was not available to schools of pharmacy in all of the UK countries to deliver inter-professional learning. They explained that schools currently did as much as they could afford. For them, funding was currently restricting the further expansion of inter-professional learning. Several respondents also mentioned that it was sometimes difficult to organise inter-professional learning with other professions as they had different education and training models. They proposed for us to work with the regulators of these professions to ensure that the emphasis on inter-professional learning was achievable.

6. Learning in practice (pre-registration) supervision

Table 13: Views on replacing the current four tutor sign-offs with more regular progress meetings between learning in practice supervisors and student pharmacists

Q13. Do you agree or disagree with our proposal to replace the current four tutor sign-offs with more regular progress meetings between learning in practice supervisors and student pharmacists?	N and % individuals	N and % organisations	Total N and %
Strongly agree	225 (43%)	35 (34%)	**260 (42%)**
Tend to agree	153 (29%)	44 (43%)	**197 (32%)**
Neither agree or disagree	54 (10%)	10 (10%)	**64 (10%)**
Tend to disagree	43 (8%)	7 (7%)	**50 (8%)**
Strongly disagree	16 (3%)	1 (<1%)	**17 (3%)**
Don't know	28 (5%)	5 (5%)	**33 (5%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

6.1. As indicated in table 13, 74% of respondents agreed with our proposal to replace the current four tutor sign-offs with more regular progress meetings between learning in practice supervisors and student pharmacists. Proportionally, slightly more organisational respondents (77%) agreed with our proposal compared with individual respondents (72%). 11% disagreed with the proposal and 5% were unsure with these findings being similar across organisations and individuals.

6.2. Just over half of respondents provided open-ended feedback to that question. The most common response provided was that more regular progress meetings would better support students' progression. Respondents also made specific suggestions in regard to meetings' frequency, training and support of supervisors, ensuring continuity in the supervision of students and quality assurance. Concerns about resources available to organise regular progress meetings were also raised. The same views to the ones captured in this section were raised during our stakeholder consultation events.

Benefits of regular progress meetings

6.3. Many responses pointed out that there are significant variations in the quality of pre-registration supervision both between and within sectors. Some respondents indicated that the engagement of pre-registration tutors with trainees could sometimes be insufficient. They explained that trainees could sometimes be considered as 'an extra pair of hands' and that they did not always receive regular feedback.

6.4. A common theme amongst respondents who provided feedback was that regular progress meetings would ensure that students could progress more consistently and continuously towards the learning outcomes. In their view, it was important for students to regularly meet their supervisors to ensure they were progressing with their learning, coping with their workload and could discuss professional issues on a regular basis. For many respondents, replacing the current four tutor sign-offs with more regular progress meetings would strengthen the quality of training.

6.5. There was common agreement that regular meetings would enable supervisors to have a better overview of a student's development. Respondents agreed that supervisors would have a better idea of how students were getting on with their learning, what their learning needs were, and would be able to support students sooner.

6.6. Respondents also welcomed a more tailored approach to students' supervision. In their view, more regular discussion of students' learning needs would give both supervisors and students an opportunity to adjust training plans more flexibly, enable students to develop faster and reduce the risk of any issue becoming a long-standing problem. For respondents, a more regular assessment of students' progress would also allow supervisors to enable willing and competent students to progress faster.

Frequency of the progress meetings

6.7. Many respondents felt that the frequency of meetings should depend on the learning needs of students. For them, assessing and giving feedback to students should be dynamic and reactive. Other respondents asked for a minimum number of progress meetings to ensure consistency between training providers. They explained that some supervisors have a heavy workload and wanted to make sure at least a minimum number of meetings between supervisors and students took place. They were of the opinion that, if a clear standard did not replace the four tutor sign-offs, there was a risk that contacts between students and supervisors would decrease.

Supervisors' training and support

6.8. A common theme was that the training of supervisors should be improved. Many respondents felt that supervisors should be appropriately trained and should benefit from ongoing support with mentoring and providing constructive feedback to students. In their view, adequate training should be provided to supervisors, so they have a clear understanding of what is expected of them and of students. For these respondents, regular progress meetings will only be successful if supervisors are supported to carry out their role as the quality of the meetings is dependent on the skills of the practice supervisor.

Supervision continuity

6.9. A number of respondents mentioned that several shorter learning in practice placements over different training sites might mean that the continuity of supervision and development of the student by one or two supervisors would be lost. They were worried that supervisors would lose the overview of the strengths and weaknesses of students and the responsibility for their full training. They were also concerned that shorter placements would make signing students' competencies more difficult.

6.10. Many respondents underlined that communication between the different supervisors would be crucial to ensure students' appropriate development. Several respondents mentioned that records of students' progress, for instance portfolios or electronic records, should be passed on from supervisor to supervisor. Some respondents were in favour of digital technology as they found the ability to upload evidence and record meetings on an online platform to be a more efficient use of time for both supervisors and students. A few respondents agreed that e-portfolios could be used as a two-way feedback stream between supervisors and students and reflect students' journeys.

Quality assurance of learning in practice supervision

6.11. Many respondents were unsure about how regular progress meetings should take place in practice. They asked about the remit and structure of the meetings, their organisation and how frequently they should take place. They also asked about the relationship between schools and training providers and questioned quality assurance mechanisms.

6.12. Several respondents pointed out that increasing the number of meetings between supervisors and students was not enough. They explained that having regular meetings would not necessarily improve the quality of the feedback provided to students. They were concerned that regular meetings could also be considered by certain supervisors as a 'tick box' exercise. For them, what was more important to tackle was the quality of the supervision to ensure students meet the learning outcomes. These respondents felt that learning in practice supervision needed to be adequately governed and monitored.

6.13. There were a few diverging views in regard to how schools should be involved in the progress meetings. Some respondents proposed that schools' representatives participated in some of the progress meetings as schools would need to have oversight of the whole learning journey. Others suggested that schools or the GPhC should quality assure students' portfolios to ensure students are supported to meet the learning outcomes. For some respondents, it was essential for schools to quality assure the progress of students and to review the progression reports submitted after each period of learning in practice. A few respondents asked whether and how the GPhC would be involved in quality assuring the learning in practice supervision. Respondents agreed learning in practice supervision needed greater quality control and assurance mechanism built in. Other respondents were concerned that schools would not have the resources to put that in place. For them, quality assuring regular progress meetings would be difficult for schools to organise within the existing funding available. Many consultation responses asked for clarification regarding schools' responsibilities and oversight of learning in practice.

Financial and resource implications

6.14. Even though a significant number of respondents agreed on the importance of having regular informal dialogue between supervisors and students, some respondents disagreed with replacing the current four tutor sign-offs with more regular progress meetings. These respondents were concerned about the impact of this proposal on the workload of the teams providing placements. They explained that some supervisors already struggle to balance their clinical workload with their supervising role and that mandating an increased number of supervision meetings could be difficult for them to achieve. Several respondents were also concerned about supplementary paperwork, as they thought it could take pharmacists further

away from doing their job. These respondents mentioned the increasing work-pressures placed on practising pharmacists and were concerned that training sites may be less keen to accept students if supervision activities took pharmacists away from their day-to-day work.

6.15. Several respondents also expressed concerns about the resources and funding available to undertake regular progress meetings. They pointed out that some training providers may not have enough resources to cope with the time required to perform regular progress meetings. They explained that the workforce is already stretched and might struggle to support candidates who do not meet the learning outcomes. These respondents thought that organising more regular progress meetings would only be viable with additional resources. They asked to be supported by appropriate funding models within the employment sectors. In their view, an appropriately funded support structure would need to cover supervisors' training and the quality assurance of placements.

Table 14: Views on replacing the current pre-registration performance standards with the learning outcomes

Q14. Do you agree or disagree with our proposal to replace the current pre-registration performance standards with the learning outcomes stated in Part 1 of the revised standards?	N and % individuals	N and % organisations	Total N and %
Strongly agree	204 (39%)	46 (45%)	250 (40%)
Tend to agree	183 (35%)	33 (32%)	216 (35%)
Neither agree or disagree	64 (12%)	9 (9%)	73 (12%)
Tend to disagree	17 (3%)	6 (6%)	23 (4%)
Strongly disagree	16 (3%)	3 (3%)	19 (3%)
Don't know	35 (7%)	5 (5%)	40 (6%)
Total N of responses	519 (100%)	102 (100%)	621 (100%)

6.16. As presented in Table 14, 74% of respondents agreed with our proposal to replace the current pre-registration performance standards with the learning outcomes stated in Part 1 of the standards. A slightly larger proportion of organisations (77%) agreed with this proposal, compared to individual respondents (72%).

6.17. Just under half of consultation respondents provided open-ended feedback to this proposal. There was general support for replacing the performance standards by the learning outcomes, although some respondents asked for guidance on how to implement this change.

Replacing the performance standards with learning outcomes

6.18. There was broad agreement that the current performance standards used to assess pre-registration trainees' progression needed to be updated in order to be relevant to current

practice. Respondents also mentioned that the current performance standards were repetitive and sometimes viewed as a tick box exercise.

6.19. Several respondents agreed that students' progression in an integrated degree should be measured by a single, coherent set of learning outcomes covering both theoretical and practical learning. From an educative perspective, respondents were also of the opinion that having one set of integrated learning outcomes made sense as it was clearer for all stakeholders involved in the initial education and training of pharmacists.

Guidance to support the use of the learning outcomes during learning in practice

6.20. Many respondents questioned how the learning outcomes should be implemented. They were unsure about how specific competencies should be demonstrated and assessed as they thought that the learning outcomes were too open to interpretation. Respondents also felt that replacing the performance standards by the learning outcomes was a significant change and that successful implementation required a high level of rigour, support and guidance. Indeed, some respondents suggested that replacing the performance standards by the learning outcomes without providing guidance could lead to variability and inconsistencies. Many respondents felt that an evidence framework providing guidance on how to implement the standards and the learning outcomes should be developed as specific examples would benefit the implementation of learning in practice.

6.21. A small number of respondents asked for guidance on when specific learning outcomes should be demonstrated and assessed.

Retaining the performance standards

6.22. A smaller number of respondents thought that the existing performance standards were valuable to both students and those supporting or assessing learning in practice. Some of them also mentioned that the performance standards provided clarity to students on what was expected of them. These respondents were of the opinion that the performance standards should be retained and updated instead of being replaced. A few respondents also preferred the performance standards as they found the learning outcomes too vague.

6.23. A few respondents were concerned that a single set of learning outcomes to be achieved over the five years of initial education and training would not provide sufficient specificity to accommodate the range of models of initial education and training.

7. The impact of the proposed changes on people sharing particular protected characteristics

Table 15: Views on our proposals benefiting any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

Q15. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below[3]?	N and % individuals	N and % organisations	Total N and %
Age	46 (9%)	4 (4%)	**50 (8%)**
Disability	37 (7%)	6 (6%)	**43 (7%)**
Gender reassignment	30 (6%)	6 (6%)	**36 (6%)**
Marriage and civil partnership	23 (4%)	2 (2%)	**25 (4%)**
Pregnancy and maternity	27 (5%)	6 (6%)	**33 (5%)**
Race	33 (6%)	6 (6%)	**39 (6%)**
Religion or belief	25 (5%)	5 (5%)	**30 (5%)**
Sex	24 (5%)	4 (4%)	**28 (5%)**
Sexual orientation	27 (5%)	5 (5%)	**32 (5%)**
None of the above	445(86%)	90 (88%)	**535 (86%)**

7.1. As Table 15 shows, 86% of survey respondents did not think our proposals would benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Those who thought our proposals would benefit people sharing particular protected characteristics most commonly selected age (8%), disability (7%), race (6%) and gender reassignment (6%).

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[3] Respondents were asked to tick all that applied.

Table 16: Views on our proposals discriminating or unintentionally disadvantaging any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

Q16. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below[4]?	N and % individuals	N and % organisations	Total N and %
Age	51 (10%)	23 (23%)	**74 (12%)**
Disability	63 (12%)	24 (24%)	**87 (14%)**
Gender reassignment	14 (3%)	5 (5%)	**19 (3%)**
Marriage and civil partnership	18 (3%)	15 (15%)	**33 (5%)**
Pregnancy and maternity	47 (9%)	24 (24%)	**71 (11%)**
Race	39 (8%)	25 (25%)	**64 (10%)**
Religion or belief	21 (4%)	12 (12%)	**33 (5%)**
Sex	22 (4%)	6 (6%)	**28 (5%)**
Sexual orientation	13 (3%)	6 (6%)	**19 (3%)**
None of the above	405 (78%)	63 (62%)	**468 (75%)**

7.3. As Table 16 shows, 75% of survey respondents did not think our proposals would discriminate or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Those who thought our proposals would negatively impact people sharing particular protected characteristics selected disability (14%), age (12%), pregnancy and maternity (11%) and race (10%) more often than the other protected characteristics.

7.4. Just over half of consultation respondents provided open-ended feedback on whether our proposed changes for the initial education and training of pharmacists would positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. The views presented below are also representative of event participants.

Age

7.5. Many of the respondents who provided feedback were concerned about the impact of our proposals on mature students.

7.6. In regard to selection and admission, respondents were worried that prescriptive academic requirements may adversely impact mature students who did not achieve the required grades at A-level or had atypical qualifications. For them, raising MPharm entry academic requirements

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[4] Respondents were asked to tick all that applied.

could potentially reduce the number of mature students who choose to study for an MPharm. Other respondents, however, pointed out that assessing applicants' skills and attributes would take into consideration the experience, knowledge and skills mature students have acquired and could benefit them.

7.7. In regard to our proposal to integrate academic and practical learning, some respondents were concerned that mature students might no longer consider studying for an MPharm degree if they had to self-finance a fifth year of education and training. They explained that mature students often have other monetary obligations such as paying a mortgage or supporting their family. Some respondents also mentioned that mature students are more likely to have caring responsibilities and so might be less able to alternate between periods of learning at the university with periods of learning in practice. In that regard, respondents thought that mature students would be more affected by routine changes and less able to relocate for their learning in practice.

7.8. A large number of respondents felt that our proposals could negatively affect young people. Their concerns focused on the assessment of applicants' skills and attributes during admission procedures. These respondents felt that young applicants might find it difficult to display professional attitudes and would struggle to demonstrate that they have the potential to be a professional pharmacist at the age of 17, 18 or 19.

Disability

7.9. A number of respondents felt that individuals with particular difficulties in communicating (for example people with autism spectrum disorders) might be negatively impacted by our proposal to assess the skills and attributes of applicants during admission procedures. They felt that if a disability made an individual less able to communicate or show empathy with others it would make it difficult for them to achieve a successful application. Other respondents believed that disabled people generally had lower grades and that setting more prescriptive academic requirements would have an impact on them joining MPharm degrees.

7.10. A few respondents were concerned that some individuals with disabilities might not be able to meet the learning outcomes because of serious health problems (for example severe visual impairments) or being less able to communicate and to show empathy. For instance, respondents felt that people with disabilities may be physically or mentally unable to help or respond in stressful situations and deliver first aid.

7.11. Several respondents were concerned about the support provided to disabled students while in learning in practice. They explained that the support provided by universities was usually better than training providers. They worried that, in an integrated degree, this lack of support from training providers might negatively impact students who also need reasonable adjustments during their training. For them, there should be early consideration of how adjustments should be organised for students during their periods of learning in practice. In their view, a greater degree of planning around placements should be undertaken to enable training providers to organise the appropriate reasonable adjustments for students with disabilities. A few respondents also indicated that disabled people may need placements closer to home, with a carpark or with a wheelchair access.

7.12. Several respondents indicated that having to undertake several shorter learning in practice placements in different organisations might negatively impact students who have physical

disabilities as they could find constant relocations challenging. Others mentioned that disabled people could be put off by having to regularly communicate their needs for reasonable adjustments to training providers. Other respondents thought that disabled students might be negatively impacted if they were no longer able to undertake their learning in practice part-time. They explained that there are significant differences in the physical and mental demands of full-time education and full-time work.

7.13. A few respondents wondered whether integrated learning would support or hinder neurodiverse students (for example students with dyslexia, or ADHD) and students with mental health problems. A small number of respondents proposed that, if done well, integrating learning may support students who prefer 'action-based learning'. However, others mentioned that integrated learning may equally pose challenges to this student group, especially when splitting the existing pre-registration year to a range of clinical settings (community pharmacy, hospital and GP surgeries). For them, this would be unsettling for some students and not give them enough time to gain a deeper appreciation of a clinical setting which interests them and/or supports their learning style.

Marriage and civil partnership

7.14. Many respondents were of the view that students who are married, pregnant or who have caring responsibilities may need placements close to home. They were concerned that organising several shorter learning in practice placements would make it more difficult for these groups. For instance, they explained that people with children are likely to find it more difficult, if not impossible, to relocate during their learning in practice. Respondents also mentioned that part-time provisions needed to be organised for students with dependents.

Pregnancy and parental leave

7.15. Respondents had diverging views on the impact of our proposals on pregnancy and parental leave. Some respondents felt that students who are pregnant or on parental leave may be disadvantaged as it might be more difficult for them to temporarily pause their education or training in an integrated programme, or because they will be less flexible to relocate for their placements. These respondents thought that the management of a 5-year course should take into consideration that some students will need to take parental leave. Other respondents were of the opinion that having the opportunity to complete learning in practice over a period of five years would benefit anyone requiring parental leave, as they would not be under the same pressure to postpone the pre-registration year in one go. These respondents proposed that students should be able to 'bank' their competencies until they return from parental leave.

Race

7.16. Many respondents were concerned that Black, Asian and Minority Ethnic (BAME) groups and non-British applicants may be disadvantaged during admission procedures. They explained that, if bias was not monitored and controlled during the selection process, these applicants might be negatively impacted by cultural differences. For them, interactive recruitment methods could lead to introducing subjectivity and biases which could negatively impact specific groups if not managed carefully. Several respondents advised that all staff involved in admissions procedures should undertake rigorous cultural training to offset the chance of any unintentional discrimination.

7.17. Several respondents also mentioned that race is strongly linked to socio-economic status and education. They explained that a disproportionately large number of BAME people live in poverty in the UK. For them, increasing the cost of pharmacy education and training would deter BAME applicants. Other respondents mentioned that raising the academic requirements for entry onto an MPharm degree may negatively impact BAME applicants. Some respondents proposed that all schools of pharmacy should have a minimum intake number for BAME students.

7.18. Several respondents mentioned that international students who wish to obtain a UK MPharm degree, but not undertake their learning in practice in the UK, might be disadvantaged by the integration of academic and practical learning as this might no longer be an option for them. Others pointed out that English was not the first language of all applicants and students. They were concerned that overseas applicants might be negatively impacted by admission procedures and might struggle with the learning outcomes focusing on communication. However, several respondents were of the opinion that overseas students would significantly improve their English while on the MPharm degree.

Religion or belief

7.19. A few respondents explained that some religious people may be reluctant to travel. In their view, if students were able to choose their training site, this group would not be negatively impacted by our proposals. These respondents felt that random allocation of placements could therefore be an issue for some religious individuals.

Sexual orientation

7.20. Several respondents felt that Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning (LGBTIQ) people are more likely to face a range of negative health experiences and can suffer from mental health problems. They mentioned that previous negative experiences in healthcare settings can prevent patients from disclosing relevant information about their sexual orientation or gender identity. They mentioned that the increased focus on person-centred care and improved communication in the standards would benefit LGBTIQ people.

8. Other impacts

Table 17: Views our proposed changes positively or negatively impacted any other individuals or groups

Q17. Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups?	N and % individuals	N and % organisations	Total N and %
Yes	313 (60%)	84 (82%)	**397 (64%)**
No	79 (15%)	5 (5%)	**84 (14%)**
Don't know	127 (24%)	13 (13%)	**140 (23%)**
Total N of responses	**519 (100%)**	**102 (100%)**	**621 (100%)**

8.1. As Table 17 indicates, 64% of respondents thought that our proposed changes would positively or negatively impact other individuals or groups. A larger proportion of individuals did not know whether the changes would impact others (24%) compared with organisations (13%). Event respondents shared similar views.

Positive impacts

On students and future pharmacists

8.2. Many respondents felt that our proposed changes would be beneficial for the development of students. In their opinion, the improved selection of students would ensure that more motivated and suitable students enter MPharm degrees. They also felt that students would be able to have an understanding of the profession and be able to decide if they wanted to become a pharmacist earlier. Others considered that learning in practice would be fairer and more consistent

8.3. A large number of respondents felt that our proposals would increase the quality of the practice of future pharmacists because their knowledge of patients would be greater, their confidence and communication skills improved, pharmacists would be more professional, clinically competent and willing to lead, make decisions and take initiatives.

8.4. A few respondents felt that the new learning outcomes might make other professions change their perception of the skills of pharmacists. Some respondents pointed out that, due to inter-professional learning, other professions would benefit from pharmacists' better understanding of their roles.

On patients

8.5. Many respondents were of the view that our proposed changes would be beneficial for patients as they would receive a higher standard of care.

On schools of pharmacy and training providers

8.6. Several respondents were of the view that the understanding of pharmacy practice of academic staff would be strengthened as they would work more closely with practising pharmacists.

8.7. Some respondents mentioned that our proposed changes would also mean that supervisors would benefit from better training and support mechanisms. They would therefore be able to develop further in their roles.

Negative impacts

On students

8.8. Many respondents commented on the financial impact of our proposals on students and were concerned that introducing an integrated degree could have a negative impact on students, and especially students from disadvantaged socio-economic backgrounds, mature students and international students. Their main concerns were that students would potentially have to pay for a fifth year of education and training and may not receive a salary during their learning in practice. Respondents also anticipated that several shorter learning in practice placements would translate to additional accommodation and travel costs for students. Respondents were concerned that school leavers would decide against studying for an MPharm degree because it would be too expensive for them.

8.9. A number of respondents were worried that, because of the increased number of placements and difficulty in organising them, students would not be able to decide where to undertake their placements and might feel less able to orientate their careers. Others were concerned that not having a continuous year of training would impede students gaining independence in their work. Training providers explained that, in their experience, students become more autonomous at the end of their training.

On schools of pharmacy

8.10. Many respondents mentioned that integration would require schools to undertake significant transitions, which would be time and resource-intensive for them. They were concerned about the resource and financial impact placed on schools. Respondents mentioned increased costs to change and run admission procedures; to secure, organise and quality assure experiential learning and learning in practice placements; to appoint and train staff; and to administratively manage programmes. Respondents felt that without funding to undertake these new tasks it would be difficult to implement them.

8.11. Several respondents were concerned that modified admission criteria would also have a financial impact on schools. They explained that disallowing unconditional offers would remove a predictable income for schools and that stricter admission requirements would also lead to a loss of income. They were concerned that schools would have to close because MPharm degrees would no longer be viable.

8.12. Other respondents queried whether university places should match learning in practice placements, and whether the number of students would be capped.

On training providers

8.13. Training providers were concerned regular progression meetings would be difficult to organise due to time constraints in the workplace. They were concerned about the impact of this proposal on the workflow of pharmacies.

8.14. Respondents were unsure about how to organise learning in practice placements, which would start at different times, last for different lengths of time, and for students who were at different stages of their initial education and training.

8.15. A few respondents were concerned that the training of students would require more support from supervisors/teams, as students would undertake their learning in practice earlier in their initial education and training, and so have less knowledge.

8.16. Training providers suggested that working with different schools of pharmacy would mean having to take into consideration different approaches and requirements, which would also be resource intensive for them. Training providers also anticipated that needing to train all staff involved in the supervision of students to a higher standard (for example to ensure supervisors have the skills to teach and assess more advanced clinical skills) and the renewal of training material/courses would be expensive. They also considered that implementing and running our proposed changes would lead to increased administration costs. Respondents worried that, because of these costs, some current training providers might stop training students. Others believed new funding arrangements should be put in place to support training providers.

8.17. Some training providers were concerned that, because schools already have training agreements with specific training providers, they would only send their students to these sites.

8.18. Even if they acknowledged it was not best practice, a number of respondents explained that certain training providers currently relied on pre-registration trainees in their yearly workforce planning. A few respondents explained that pre-registration trainees were counted in departmental workforce and supported weekend service provisions. They also mentioned that, with cuts to pharmacy budgets, a funded member of staff was indispensable in some places. For them, splitting the pre-registration year in several shorter placements at different stages of initial education and training would disrupt workplaces.

8.19. Training providers also explained that the current length of pre-registration placements enables employers to train students to their processes. Several providers, mainly from community and hospital sectors, explained that currently they hired pre-registration trainees after they registered as part of their recruitment strategies. They were concerned this recruitment route could be jeopardised by shorter learning in practice placements and that employers would have to spend more money on the recruitment and the training of junior pharmacists.

8.20. Some respondents were concerned that the introduction of shorter periods of learning in practice would mean that students would look for placements close to where they lived and that this would negatively impact training providers located in less populated and rural areas.

Next steps

1.1. This Consultation analysis report will be presented, alongside an Equality impact assessment (EIA), to the GPhC Council in September 2019.

1.2. We will be aiming to finalise new standards following a further round of stakeholder engagement and discussion. These discussions will need to explore issues relating to implementation and funding, and take account of what will be needed from the future pharmacist workforce to meet the needs of each country. We are planning to begin these further discussions with stakeholders in Autumn 2019 even if discussions might be carried out over a period of time.

1.3. We believe progress can be made more quickly in regard to the standards relating to selection and admission and equality, diversity and fairness as these are not dependent on decisions about integrating the five years of education and training. We will therefore review and engage on revised standards for these two domains in the Autumn and present them to the GPhC Council at a future meeting.

Appendix 1: The consultation

1. Policy background

1.1. One of our core regulatory activities is setting standards for the education and training of pharmacy professionals, including pharmacists, pharmacy technicians and pharmacist independent prescribers. Currently, we are in the middle of a significant review programme covering all our education standards, as stated in our **Strategic Plan 2017-2020**. To date, revised standards for the initial education and training of pharmacy technicians and standards for the education and training of pharmacist independent prescribers have been agreed.

1.2. The most common form of initial education and training (IET) for pharmacists in Great Britain is a four-year MPharm degree accredited by us, followed by 52 weeks of pre-registration training in one or more sectors of practice. During the pre-registration period trainees apply their knowledge and skills, and demonstrate their competence in an employment practice-setting. Following successful completion of this, they are required to pass a registration examination before being able to apply to join the pharmacist register. These requirements reflect the UK's current membership of the European Union, and Directive 2005/36/EC, under which pharmacists must undergo at least five years' full-time (or part-time equivalent) initial education and training. This must be made up of at least four years' academic study and at least six months of patient-facing training in a community or hospital pharmacy towards the end of the five years. Schools of pharmacy (schools) are responsible for the design and delivery of the MPharm degree, which must meet the standards for the initial education and training of pharmacists (the standards), in order to be accredited by us.

1.3. The **current standards** were published in 2011. They set out our requirements for course providers (standards 1 to 9) and the skills, competencies and behaviours that students and trainees must have acquired before registering with the GPhC (standard 10 – learning outcomes). **Revised learning outcomes** were produced in 2013 (including input from key stakeholders) but this was not part of a full standards review and these learning outcomes were not implemented, as expected changes in government policy were not continued. Pre-registration requirements were published in a separate document, known as the pre-registration manual. The manual covers the knowledge, skills and competences that a pre-registration trainee needs to acquire by the end of the 52-week placement. The performance standards precede the 2011 standards and have not been reviewed after the introduction of the current standards.

1.4. The pace of change in pharmacy has increased in recent years with greater use of technology, and an increase in the range of services offered to people. There is also an increased expectation that pharmacists can help relieve some of the pressures in the wider NHS. The pharmacist's role as a front-line healthcare professional has continued to develop. It takes them more and more often into GP practices, care homes and people's homes, as well as into the more familiar settings of community pharmacy, hospitals, industry and academia.

1.5. Pharmacists need to be equipped to play a central role in providing clinical services to people in these diverse working environments. They also need to operate in multi-professional teams

across health and care settings, contributing to the improvement of the health and wellbeing of people.

1.6. In order to revise the standards, we commissioned research on pharmacists' preparedness for practice, met with all schools of pharmacy, convened several expert groups, asked accreditation panel members and inspectors for their views, and engaged with the three countries' training commissioning bodies. We then drafted revised standards, before consulting on them.

1.7. Between January and April 2019, we consulted on our proposals for the initial education and training of pharmacists.

2. Summary of our proposals

2.1. In order to ensure that future pharmacists are appropriately prepared for their future roles, we proposed key changes in the following areas:

- **Learning outcomes:** focused on four themes – person-centred care; professionalism; professional knowledge and skills; and collaboration. The proposed learning outcomes retain the critical importance of science as the underpinning feature of initial education and training for pharmacists, but have a greater focus on applying that scientific knowledge in practice. The learning outcomes are more heavily focused on clinical skills, multi-professional learning, and the importance of communicating effectively with patients and members of the public. We see this increased focus on clinical and communication skills and multi-professional learning as essential to equipping pharmacists with the flexibility they will need in the future. We also believe it will develop the confidence of pharmacists to play a leading role in person-centred care – something which has been raised with us consistently while we have been developing these new standards.

- **Standards for providers:** we proposed several changes to our standards for course providers. In regard to equality, diversity and fairness, we suggest strengthening our standards by requiring providers to conduct an annual review of student performance and admissions by the protected characteristics as set out in the Equality Act 2010. We will also require evidence of the action taken to examine the reasons for any differences and to address the situations where students are disadvantaged.

- **Integrating the five years of initial education and training:** in order to deliver the learning outcomes with the increased focus on clinical skills, on communicating with patients and on working effectively with other health and care professionals, we believe there must be a much stronger link between the currently separate elements of academic study in the MPharm degree and the practical experience in the pre-registration year. As a result, we proposed setting the learning outcomes to be achieved over five years. That would require universities, employers, health education and training organisations and those responsible for funding to work collaboratively to achieve this. We did not propose specific models stating how this could be achieved. We believe there are likely to be different ways and models both within and across the countries of Great Britain. We will ensure that our accreditation methodology allows for diversity and innovation in delivery.

- **Selection and admission:** we proposed to strengthen the standards by requiring providers to assess the values of prospective students in addition to their academic qualifications. By that

we mean their interest in person-centred care, ability to work with other people, professionalism, problem-solving abilities, and numeracy skills. To help achieve this we would require providers to build interactive activities into their admissions processes, for example multiple mini-interviews and group work. As well as contributing to an assessment of professional skills and attributes, this will also allow providers to assess the overall communication skills of prospective students.

- **Experiential learning and inter-professional learning:** we proposed that student pharmacists must have exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competency to achieve the learning outcomes. Our proposed standards also state that student pharmacists must participate in inter-professional learning. Engagement with students from other health and care professions would begin at an early stage, progressing to more complex interactions. This would enable student pharmacists to meet the GPhC learning outcomes.

- **Learning in practice supervision:** as we are proposing to set learning outcomes for five years, it follows there would be no separate set of pre-registration performance standards. The learning in practice components of the course would count towards the registration requirement for 52 weeks of practical learning. We would expect a more rigorous and structured approach to learning in practice with more regular and documented progress meetings.

3. About the consultation

Overview

3.1. The consultation was open for 12 weeks, beginning on 9 January and ending on 3 April 2019. To make sure we heard from as many individuals and organisations as possible:

- we launched an online survey, which was available for individuals and organisations to complete throughout the consultation period. We also accepted postal and email responses

- we organised a series of stakeholder events and a webinar aimed at pharmacy professionals, pharmacy service users, organisations and other interested parties

- we met with a number of key stakeholders across the three countries we regulate

- we attended a series of stakeholder events, including Local Pharmaceutical Committee (LPC) meetings across England

- we promoted the consultation through a press release to the pharmacy trade media, via our social media and through our e-bulletin Regulate

- we created a toolkit of materials for organisations to disseminate information about the consultation to their members, including a press release and a presentation

- we sent several reminders to the consultation before the closing date.

Survey

3.2. We received a total of **650** written responses to our consultation. **542** of these respondents identified themselves as individuals and **108** responded on behalf of an organisation.

3.3. Of these, **621** had responded to the consultation survey. 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.

3.4. Alongside these, we received **29** responses from individuals and organisations writing more generally about their views.

Stakeholder events

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

- We held **three** stakeholder events in London, Cardiff and Edinburgh, reaching **86** pharmacy stakeholders.

- We spoke at **33** speaking engagements across England, Scotland and Wales, reaching **1,310** stakeholders including pharmacy professionals, educators, employers, students and pre-registration trainees.

- We hosted an online webinar, which **900** stakeholders have viewed.

Patient focus groups

3.6. We organised **three** patient focus groups, held in London, Cardiff and Glasgow, and attended by **58** members of the public.

3.7. These focus groups provided valuable insights regarding pharmacy users' expectations.

4. Our approach to analysis and reporting

Overview

4.1. We have considered every response received, as well as notes from stakeholder meetings and events, in the development of our qualitative analysis of themes and issues raised in the consultation. Our thematic approach allows us to represent fairly the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events.

4.2. The different routes through which individuals and organisations could contribute to the consultation meant that some duplication was inevitable. For example, some organisations have met with us at one-to-one meetings and events, and have also submitted a written response. Some organisations were also able to mobilise individual members to respond to us directly.

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

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

4.5. If there were substantial differences between the views given in the consultation survey and those raised at stakeholder events, these differences are highlighted in the analysis.

4.6. For transparency, Appendix 1 provides a list of the organisations that have engaged in the consultation through the online survey, email responses and/or their participation in meetings and events. A small number of organisations asked for their participation to be kept confidential and their names have been withheld.

4.7. The consultation questions are provided in Appendix 2.

Quantitative analysis

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

4.9. 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.

4.10. A small number of multiple responses (10 in total) were received from the same individuals. These were identified by matching on email address and name. In these cases, the individual respondent's most recent response was included in the quantitative analysis, and all qualitative responses were analysed.

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

4.12. Figures in the report are shown without decimal places and have been rounded to the nearest whole number. This approach means that the percentages reported in the tables do not always add up to 100%. This rounding also results in differences of up to one percentage point when combining two or more response categories. In addition, whenever a figure of less than 1% has been reported in the tables, it has been represented as <1%.

4.13. All questions were mandatory, but routing was used where appropriate to enable respondents to skip questions that weren't relevant.

4.14. Cells with no data are marked with a dash.

Qualitative analysis

4.15. This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations, email and postal responses, and notes of stakeholder, patients and members of the public engagement events.

4.16. 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.

4.17. 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 of the data.

4.18. Prevalence of views was identified through detailed coding of written responses and analysis of feedback from stakeholder events using the themes from the coding framework. The frequency with which views were expressed by respondents is indicated in this report with themes presented in order of prevalence. For example, the terms '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

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

4.20. 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 2: Respondent profile

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

Category of respondents

Table 18: Responding as an individual or on behalf of an organisation

Are you responding: (Base: all respondents)	Total N	Total %
As an individual	519	84%
On behalf of an organisation	102	16%
Total N of responses	**621**	**100%**

Profile of individual respondents

Table 19: Countries

Where do you live? (Base: all individuals)	Total N	Total %
England	448	86%
Scotland	36	7%
Wales	20	4%
Northern Ireland	7	1%
Other	8	2%
Total N of responses	**519**	**100%**

Table 20: Respondent type

Are you responding as: (Base: all individuals)	Total N	Total %
A pharmacist	409	79%
A pharmacy technician	32	6%
A pre-registration trainee pharmacist	26	5%
A pre-registration trainee pharmacy technician	0	0%
A pharmacy student	23	4%
A member of the public	8	2%
Other	21	4%
Total N of responses	**519**	**100%**

Table 21: Prescribers

Are you qualified as: (Base: pharmacists)	Total N	Total %
An independent prescriber	70	17%
A supplementary prescriber	3	<1%
Both an independent and supplementary prescriber	25	6%
None of the above	311	76%
Total N of responses	**409**	**100%**

Table 22: Pharmacy owners

Are you a pharmacy owner or employer? (Base: individual pharmacists & Pharmacy technicians)	Total N	Total %
Yes	38	9%
No	403	91%
Total N of responses	**441**	**100%**

Table 23: Main area of work

Sector (Base: individuals excluding pharmacy students and members of the public)	Total N	Total %
Community pharmacy	170	35%
Hospital pharmacy	143	29%
Prison pharmacy	2	<1%
Primary care organisation	25	5%
GP practice	30	6%
Care home	1	<1%
Pharmaceutical industry	12	2%
Research, education or training	73	15%
Other	32	7%
Total N of responses	**488**	**100%**

Table 24: Size of community pharmacy

Size of pharmacy chain (Base: individuals working in community pharmacy)	Total N	Total %
Independent pharmacy (1 pharmacy)	25	15%
Independent pharmacy chain (2-5 pharmacies)	29	17%
Small multiple pharmacy chain (6-25 pharmacies)	22	13%
Medium multiple pharmacy chain (26-100 pharmacies)	16	9%
Large multiple pharmacy chain (Over 100 pharmacies)	78	46%
Total N of responses	**170**	**100%**

Table 25: Design and/or delivery of pharmacist education and training

Are you involved in the design and/or delivery of pharmacist education and training? (Base: all individuals excluding pharmacy students)	Total N	Total %
Yes	217	44%
No	279	56%
Total N of responses	**496**	**100%**

Table 26: Main role in the design and/or delivery of pharmacist education and training

What is your main role in the design and/or delivery of pharmacist education and training? (Base: those involved in pharmacy education and training)	Total N	Total %
Head of School	4	2%
Course or programme leader	22	10%
University tutor/lecturer	32	15%
Teacher practitioner	12	6%
Pre-registration tutor/supervisor	60	28%
Pre-registration employer	12	6%
Other	75	35%
Total N of responses	**217**	**100%**

Profile of organisational respondents

Table 27: Pharmacy organisation

Is your organisation: (Base: all organisations)	Total N	Total %
a pharmacy organisation	78	76%
a non-pharmacy organisation	24	24%
Total N of responses	**102**	**100%**

Table 28: Type of organisation

Please choose the option below which best describes your organisation (Base: all organisations)	Total N	Total %
Organisation representing patients or the public	2	2%
Organisation representing pharmacy professionals or the pharmacy sector	22	22%
Independent pharmacy (1 pharmacy)	2	2%
Independent pharmacy chain (2-5 pharmacies)	3	3%
Small multiple pharmacy chain (6-25 pharmacies)	3	3%
Medium multiple pharmacy chain (26-100 pharmacies)	2	2%
Large multiple pharmacy chain (over 100 pharmacies)	4	4%
NHS organisation or group	30	29%
Research, education or training organisation	27	26%
Government department or organisation	1	<1%
Regulatory body	0	0%
Other	6	6%
Total N of responses	**102**	**100%**

Table 29: Involvement in the delivery or commissioning of pharmacist education and training

Is the organisation you represent involved in the delivery or commissioning of pharmacist education and training? (Base: all organisations)	Total N	Total %
Yes	75	74%
No	27	26%
Total N of responses	**102**	**100%**

Table 30: Role in the delivery or commissioning of pharmacist education and training

What is your organisation's main role in the delivery or commissioning of pharmacist education and training? (Base: organisations involved in pharmacist education and training)	Total N	Total %
Delivery of the MPharm	23	31%
Delivery of pharmacist pre-registration training	30	40%
Commissioning of pharmacist education and training	3	4%
Other	19	25%
Total N of responses	**75**	**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 3: Organisations

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

Abertawe Bro Morgannwg Health Board

Academy of Pharmaceutical Sciences (APS)

Association of Independent Multiple Pharmacies (AIM)

Aston University

Avicenna

Betsi Cadwaladr University Health Board

Birmingham and Solihull and Wolverhampton Local Pharmaceutical Committees

Board of Community Health Councils in Wales

Boots Pharmacists Association

Boots UK

Britannia Pharmacy

British Oncology Pharmacy Association (BOPA)

British Pharmaceutical Students' Association (BPSA)

Buckinghamshire Local Pharmaceutical Committee

Burdon Pharmacies

Buttercups Training Ltd

Cambridge University Hospitals

Camden and Islington Local Pharmaceutical Committee

Cardiff University

Central and North West London NHS Foundation Trust (CNWL)

College of Mental Health Pharmacy (CMHP)

Community Health Voice

Community Pharmacy Humber

Community Pharmacy NI (CPNI)

Community Pharmacy Scotland (CPS)

Community Pharmacy Wales

Community Pharmacy Wales (Aberystwyth)

Community Pharmacy Wales (Cardiff)

Community Pharmacy Wales (Narberth)

Community Pharmacy Wales (North Wales)

Community Pharmacy Wales (Swansea)

Company Chemists' Association (CCA)

Coventry Local Pharmaceutical Committee

Chief Pharmaceutical Officers (CPhO)

De Montfort University

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Local Pharmaceutical Committee

Directors of Pharmacy Scotland

Dorset Local Pharmaceutical Committee

East Midlands Pre-registration Training Group

East Sussex Better Together VTS Pilot Programme Board

Gloucestershire Hospitals NHS Foundation Trust

Great North Clinical Pharmacy Network (NE England)

Greater Manchester Local Pharmaceutical Committee

Guild of Healthcare Pharmacists (GHP)

Health Education and Improvement Wales (HEIW)

Health Education England (HEE)

Healthcare Improvement Scotland

Healthwatch Barnsley

Highland Pharmacy Education and Research Centre

James Mckeever Ltd Muirend Pharmacy

Keele University

King's College Hospital

King's College London

Kingston University

Leeds Teaching Hospitals NHS Trust

LGBT Foundation

Liverpool John Moores University

MB Health

McKesson UK

MediCare Pharmacy Group

Medicure Pharmacy

Michael Franklin Chemists Ltd

Monkbar Pharmacy

National Pharmacy Association (NPA) - England

National Pharmacy Association (NPA) - Scotland and Wales

Newcastle University

NHS Barnsley Clinical Commissioning Group

NHS Education for Scotland (NES)

NHS England and NHS Improvement

NHS Grampian

NHS Grampian Area Pharmaceutical committee

NHS Greater Glasgow and Clyde Area Pharmaceutical Committee

NHS Lothian

Norfolk and Suffolk NHS Foundation Trust (NSFT)

Norfolk Local Pharmaceutical Committee

Northern Lincolnshire and Goole NHS Trust

Nottingham University

Nottingham University Hospitals NHS Trust

O'Briens Pharmacy Group

PAGB

PCT Healthcare Ltd

Pharmaceutical Services Negotiating Committee (PSNC)

Pharmaceutical Society of Northern Ireland (PSNI)

Pharmacists' Defence Association (PDA)

Pharmacy Forum of Northern Ireland

Pharmacy London (London-wide Local Pharmaceutical Committee Group)

Pharmacy Schools Council (PhSC)

Pharmacy Schools Council (PhSC) Postgraduate Pharmacy Task Group

Pre-registration Advisory Group Yorkshire and Humber

Preston's College

Primary Care Pharmacy Association (PCPA)

Queen's University

Research Strategy Implementation Group (RSIG)

Robert Gordon University

Rowlands Pharmacy

Royal College of General Practitioners (RCGP)

Royal College of Physicians (RCP)

Royal Pharmaceutical Society (RPS)

Royal Pharmaceutical Society (RPS) Scotland

Royal Pharmaceutical Society (RPS) Wales

Sandwell Local Pharmaceutical Committee

Scottish Government

Scottish Hospital Pharmacist Education and Training Group

Sefton Local Pharmaceutical Committee

Sheffield Teaching Hospitals NHS Trust

South Staffordshire Local Pharmaceutical Committee

South Tees Hospitals NHS Foundation Trust

South West London and St George's NHS Trust

Southern Health and Social Care Trust

Swansea University

Tees Esk and Wear Valleys NHS Foundation Trust

UK Black Pharmacist Association

UK Healthcare Education Advisory Committee (UKHEAC)

University College London

University Hospitals of Leicester

University of Bath

University of Birmingham

University of Bradford

University of Brighton

University of Central Lancashire

University of East Anglia

University of Hertfordshire

University of Leeds

University of London

University of Manchester

University of Nottingham

University of Reading

University of Strathclyde

University of Sussex

Welsh Government

Welsh Pharmaceutical Committee

Western General Hospital, NHS Lothian

Worcestershire Acute Hospitals NHS Trust

York Teaching Hospital NHS Foundation Trust