Plans are afoot to overhaul pharmacy education and training in England and the Government has recently announced its plan to create a new body Health Education England to oversee the process.

How pharmacy education and training is being shaped

By Matthew Wright, BPharm, MRPharmS

Aisha is a junior pharmacist. She studied pharmacy in the West Midlands, did her preregistration training in the acute trust near her family home further north, and is now part way through a clinical diploma at the same hospital. It is hard work, though her line manager assures her it will all be worthwhile. But the truth is that Aisha is losing heart. She found the prereg year pretty tough — she felt her university course did not prepare her well for the challenges of working on the ward. And she is struggling to picture a natural path for her career. She has heard that there is a consultant pharmacist at a neighbouring trust, but as for how to become that good . . .

It is fair to say that pharmacists do not enjoy the same established career pathways as doctors. However, that might be set to change if plans, already three years in the making, come to fruition. The previous Government kick-started a process of modernising healthcare education, with the creation of Medical Education England (MEE). In February 2009, under the MEE umbrella, the Modernising Pharmacy Careers (MPC) programme board was charged with re-envisioning how pharmacy education and training might be delivered — from undergraduate education to foundation training and beyond.

Keith Ridge, chief pharmaceutical officer at the Department of Health and MPC co-chairman, believes that the undergraduate pharmacy course is in need of some reform to bring clinical training into the workplace. Accordingly, workstream I of MPC has been looking at the period of pharmacy education and training up to the day of registration. Key proposals for reform include having:

- A single five-year period of teaching, learning and assessment that leads to graduation and registration on the same day
- Universities and employers jointly responsible for delivering the integrated programme and signing off successful trainees
- The current 12-month preregistration training year split into two six-month practice placements (one in year 4 and the other in year 5)
- A single application process for the major practice placements which has the full involvement of employers

Dr Ridge stresses the importance of maintaining the science and rational thinking around decision-making and patient care. “In order to do that, the undergraduate education needs to change and the preregistration training too,” he maintains.

Much to discuss

The MPC programme board submitted its proposals for reform to the Secretary of State for Health in June 2011, Dr Ridge explains. “The Secretary of State responded and asked officials from the DH and the Department for Business, Innovation and Skills [BIS] to consider the proposals on the basis of cost-effectiveness, affordability and
Health Education England (HEE) is planned to be established as part of the Government’s wider reforms of health and social care. Through primary legislation it is expected to become a non-departmental public body, operating on a permanent statutory basis at arm’s length from the Department of Health and remaining accountable to the Secretary of State for Health.

According to the DH, HEE’s purpose is to ensure that the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement. HEE will take over responsibility for allocation of the “multi-professional education and training” (MPET) levy. An “education outcomes framework” is also under development, which will set expectations to ensure the investment in health and public health workforce development delivers high-quality outcomes.

Box 1: From MEE to HEE

How HEE will be different to MEE
Medical Education England (MEE) was set up in 2009 as an advisory body on the future of professional education and training for medicine, dentistry, pharmacy and healthcare scientists, and it has a programme board for each. HEE is to build on the advisory work of MEE; rather than having mainly an advisory remit, HEE is also planned to fulfil the executive functions described above. HEE will also include the DH advisory boards for nursing and midwifery for the allied health professions.

If the Health and Social Care Bill is passed, HEE will become a “special health authority” in the summer, with a view to it becoming operational in October 2012 and assuming full executive powers from April 2013 when strategic health authorities are set to be disestablished. Local education and training boards will be set up under HEE to take over necessary functions, such as postgraduate deaneries for medicine, from the SHAs.

How EEE will be different to MEE
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It has taken a lot of time to digest and contextualise that amount of information. But there is no reduction in commitment to workstream II.

The scope of the workstream has certainly expanded. It now covers both pharmacist and pharmacy technician careers and is also taking into account the wider pharmacy workforce, including assistants working at Agenda for Change bands 1–4 in the NHS, as well as dispensary and counter assistants in the community.

Chris Green was involved in the process of evidence-gathering for workstream II, in his role as chairman of the United Kingdom Clinical Pharmacy Association. And he makes no bones about its importance: “At the moment there is a career structure in the NHS in terms of pay and banding but, with the exception of consultant pharmacist posts, once pharmacists have done their early years clinical diploma that’s the end of any sort of formally recognised development. That is a generalisation but it’s largely the picture.”

Dr Green goes on: “There needs to be some kind of practitioner development pathway, probably based on a framework, with some element of professional recognition.
and peer review along the way. We need to move away from the picture where ‘you’re only as good as you say you are’. That’s not really good enough in terms of patient care and service delivery.”

Professor Bates believes that the challenges in getting workstream II right come from having a wide and varied set of stakeholders in the process — “quite legitimately,” he says. “The stakeholders have provided a comprehensive body of evidence to workstream II, and I think there is a lot of synergy within the constituency of practitioners.

“The people with the understanding and expertise to move things forward are the practitioners themselves in all the sectors that we represent. So one very purposeful role of the RPS is to gather and share examples of best practice and the evidence for best practice — and present that back to the profession in a way that helps us all move on and, of course, help with MPC workstreams.”

**In our hands**

Pharmacists need a continuing, systematic education process from day 1 onwards, suggests Professor Bates, adding: “There ought to be, in educational design, a seamless experience of support and development going through preregistration to postregistration, continued development and progression. That all needs to fit together. The RPS sees itself as a central support and facilitator to signpost, share and facilitate a seamless infrastructure for practitioner development.”

Professor Noyce expresses a similar sentiment: “What we have with MPC is policy-makers, the professional bodies of practitioners and academics all within one forum, and therefore with a shared agenda.

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**Reflections of an independent prescriber**

**How I can support depressed patients**

By Rachel Hall, MRPharmS

Half of patients with long-term conditions will suffer from depression. So it is no surprise that I come across patients on a daily basis who are suffering with the condition, whether or not it has been formally diagnosed.

Occasionally, I feel that it is appropriate to diagnose patients with depression myself, especially if a patient is particularly distressed since this often has a huge impact on their physical health. I certainly do not take this decision lightly — I weigh up the benefits of making a diagnosis and prescribing an antidepressant or referring a patient to another service (eg, counselling or cognitive behavioural therapy) against the risks of not doing so and asking him or her to book an appointment with a GP. I know that, in some cases, a patient will choose not to book another consultation, or that his or her ability to make this decision could be hindered by the way they are feeling or the availability of appointments. There is no right or wrong in this situation and you need to decide what to do on a case-by-case basis.

In 2008 I completed a clinical diploma module on mental health because I knew that I would be coming across many such cases, and it made me realise just how much I didn’t know about mental health problems. It highlighted the complexity of psychiatric conditions and the risk attached to the decisions we make as practitioners.

The patient health questionnaire—9 (PHQ-9) is a useful tool for screening patients who you suspect are suffering from depression. Although the tool has not been validated in general practice, it has been included as a Quality and Outcomes Framework indicator. Of course, these types of tools do not replace clinical judgement, but they can be useful to aid diagnosis and track a patient’s progress.

In some cases, I will discuss a particular patient with one of my GP colleagues, since they have more experience than me in dealing with people with depression.

As a practitioner, you need to make the decision whether or not you feel competent to prescribe — and diagnose — in any given situation. Certainly, I have seen first-hand what a difference it can make to patients when they realise that you can help them.

Rachel Hall is clinical pharmacist at the Old School Surgery, Bristol