QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Epsom and St Helier University Hospitals NHS Trust

Pharmacy

Risk-based Review

Quality Review report

Date: 7 June 2016

Final Report

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Quality Review details

Background to review	The visit to Epsom and St Helier University Hospitals NHS Trust was the third London Pharmacy visit to review the training environment, support and supervision that pre-registration pharmacists and pre-registration trainee pharmacy technicians were receiving within a London Local Education Provider. The pre-visit survey conducted via Survey Monkey as well as the documentations within the evidence bundle provided by the Trust, highlighted areas for development. Therefore, the focus for this visit was geared towards capturing and helping further develop these identified areas. No local faculty group (LFG) or equivalent group minutes were received for review prior to the visit.
Specialties / grades reviewed	All the pre-registration pharmacists (PRPs) and pre-registration trainee pharmacy technicians (PTPTs) from Epsom Hospital and St Helier Hospital were invited to attend the visit. The trainees were rotational and work across both sites.
Number of trainees and trainers from each specialty	The visit team met with three PRPs and two year-two PTPTs. It was reported that one PRP was on leave on the day of the visit. The number of trainers who attended the visit were as follows: Two PTPTs' educational supervisors, three PRPs' educational supervisors; Four dispensary practice supervisors, two technical services practice supervisors, One chief pharmacist, a deputy chief pharmacist / acting PTPT education programme director (EPD) and one acting PRP pharmacy education programme director (EPD).
Review summary and outcomes	The visit team was grateful for the warm welcome and the well-organised quality review to pharmacy. All the sessions were well attended. Although, the visit team had some serious concerns in regards to pharmacy education and training, no immediate mandatory requirement was issued in this instance. During the visit, it became evident that the Trust had a vast opportunity to provide rich and varied education for pharmacy trainees. It was reported that the Trust had a structured induction process which occurred across both sites and the training within the pharmacy production unit as well as the medicine information unit was robust. Other areas that were described as working well were as follows: • It was reported that trainees were allocated protected time for learning. • The pharmacy department had a 'buddying' system in place as a support mechanism for all trainees and staff. • The visit team heard that some of the supervisors were very enthusiastic and willing to support the trainees in gaining valuable experience. • The visit team heard that PRP trainees were allocated their own ward when nearing the end of their training as further preparation for future independent work. The need for the organisation of Local Faculty Group meetings (LFG) was obvious during the visit; especially, as crucial feedback to trainees as well as trainers in regards to education and training were reported to be mostly self-

directive and unstructured. The trainees also reported not being heard when concerns were raised about pharmacy training. The pharmacy education leads (PEL) recognised that the lack of a well-designed educational plan had caused discrepancies in the delivery of training within certain areas of pharmacy training within Epsom and St Helier University Hospitals NHS Trust.

The following were areas that the visit team identified as requiring improvement:

- There were inconsistencies in how trainees' and trainers' objectives were set out and managed adequately within each department.
- The lack of effective, transparent and clearly understood educational governance systems and processes were highlighted by the absence of a robust feedback mechanism.
- Trainees reported that on infrequent occasions when working late evenings or weekends, they had been unsupervised in the department or had worked days in excess of 12 hours with inadequate breaks in between and this was deemed a serious concern in regards to patient safety.
- The visit team noted that there was no consistent process for assessing and documenting trainees' competencies to undertake dispensed duties before these were assigned to them.
- It was reported that there was currently no staff in post with a primary focus on pre-registration pharmacists or preregistration pharmacy technicians. The Principal Pharmacist, SWL Elective Orthopaedic Centre was acting up into the role of Pre-Registration Education Programme Director and had the primary responsibility for PRPs.
- Although there was potential and willingness for pharmacy trainees to participate in multi-professional training, it was reported that no multi-professional learning opportunities were available at the time of the visit.
- The visit team noted that the technologies available at the Trust were not effective to sufficiently support learning at the Trust.
- The visit team was informed that a decision whether to employ into HEE pre-registration pharmacy technician commissions commencing September 2016 had not yet been made and the impact of this on a departmental workforce strategy and plan was unclear.

The visit team strongly believed that the establishment of a well-structured LFG would alleviate considerable concerns that were noted during the visit and was keen to help the Trust if so required.

Educational overview and progress by Chief Pharmacist and Pharmacy Education Leads

Pharmacy at Epsom and St Helier University Hospitals NHS Trust (ESHT) was described as one service being provided across two hospitals (Epsom and St Helier Hospitals) despite having varying service needs. The visit team heard that there were specialist pharmacists based at each hospital but working across both.

The visit team was made aware that the Trust had a transformation programme designed to improve patient flow. There had been changes to service design of pharmacy services within the Trust; there had been uncertainty about a possible demerger previously and there had also been actions to improve efficiency such as the centralisation of stores and distribution at the St Helier site. The planned to outsource outpatient dispensing and were at the tender award stage.

The department was still looking into the best suited strategies to develop seven day services. The department was open on Saturday mornings only and the focus was on supply of medicines rather than a clinical service. Since April 2016, pharmacy had started an enhanced service to acute medicine unit on bank holidays which ran on a voluntary staffing basis.

The senior management of pharmacy recognised that delays in discharging patients still happened due to 'to-

take-out' (TTO) prescriptions not being appropriately communicated to the pharmacy department in a timely manner. The pharmacy were participating in ward huddles to facilitate and identify priorities for discharge. This project was at an early stage in its implementation and it was currently too early to determine the impact on patient flow. The need for more medicine management technicians was expressed but funding was cited as the main obstacle to this.

There had been a fire in the Production Unit in February 2016 which remained closed at the present time.

The Pharmacy education lead (education programme director, EPD) was reported to be on maternity leave. Her post was being covered by two other staff in the department in addition to their current roles; one for PTPTs and one for PRPs. The Trust reported that locum and bank staff support was provided to provide some capacity for the Principal Pharmacist to take on Education responsibilities. The visit team felt that this provided capacity for operational and routine activity but doubted this would cover the strategic leadership and senior leadership expected of a Principal Pharmacist.

The planned regional change to PTPT education provision was discussed. The Trust will have a choice of two providers but has not decided which one it will use yet. It has also not decided whether it will fill the HEE allocated PTPT commissions for 2016/17.

The department was exploring effective models of how to conduct formalised Local Faculty Group (LFG) meetings for both PTPT and PRP trainees. A start date for implementing an LFG has not yet been determined.

Pharmacy had implemented a 'buddying' system so that trainees and staff would have further support apart from the generic line management structure.

Staff were not aware of a Trust Education Strategy. The key educational priorities for the pharmacy department were:-

- delivering the PTPT programme with a lack of NVQ assessors
- training newly qualified pharmacists, particularly taking into account the additional training required for those that have transferred from community pharmacy
- Training more pharmacist prescribers (in line with the recommendations of the Carter review)
- working on improving feedback to trainees

Quality Review Team			
Lead Visitor	Gail Fleming, Head of Pharmacy, Health Education England London and South East	**External Representative** (PTPT)	Nicola Arnold, Chief Pharmacy Technician Education Programme Director, Royal Surrey County Hospital NHS Foundation Trust
External Representative (PRP)	Alice Conway, Lead Pharmacist Education and Development Programme Director, Brighton and Sussex University Hospitals NHS Trust	**Observer**	Lynn Walsh, Chief Pharmacy Technician Education and Training, Imperial College Healthcare NHS Trust
Scribe	Deepa Somarchand, Quality Support Officer	**Lay Member**	Ryan Jeff, Lay Representative

Findings

GPhC Standard 1) Patient Safety

Standards

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

Consider supervision of trainees to ensure safe practice and trainees understanding of codes of conduct

Ref	Findings	Action required? Requirement Reference Number
Ph. 1.1	**Patient safety** Trainees expressed concerns with regards to the training they were receiving and how it was being assessed prior to undertaking assignments at St Helier Hospital, especially within the dispensary. An incident was described where a trainee was asked to dispense controlled drugs after 20 minutes training. They had voiced concerns and as a result had received additional training. Trainees also reported isolated occasions where at St Helier they had worked over their required time until late in the evening and had been left unsupervised in the dispensary. Also on rare occasions, they had worked for over nine hours without a break.	Yes. Please see Ph. 1.1
Ph. 1.2	**Serious incidents and professional duty of candour (Error reporting)** Trainees reported being aware of the Datix reporting system.The visit team heard that the dispensary department had a 'near miss slip' log system that was reviewed every month and reported within the senior management meeting. An error meeting had recently been initiated where feedback on released errors and near misses was being provided and the learning from released errors was routinely shared at general staff meetings. It was reported that the dispensary department had an internal pharmacy error managing system and this was run as a supportive culture as opposed to a blame culture. Any errors or near misses would be discussed by the Dispensary PS with the trainee. They would informally make the ES aware. All trainees were aware of the whistleblowing policy.	
Ph. 1.3	**Appropriate level of clinical supervision** The visit team heard that the pharmacy production unit had an in-house training structure whereby a training manual with objectives was used and this was reviewed at the end of rotations. However, the dispensary unit at St Helier Hospital was reported to have no such training manual; furthermore, concerns were raised about the support provided by most supervisors, especially during out of hours working. The visit team heard that the Trust had specialist pharmacists at each site who worked across both hospitals. Trainees reported that due to impromptu changes to PS rotations particularly in relation to clinical rotations, not all supervisors were aware of the education and training objectives. It was reported that there were no formal systems and processes in place to ensure that trainees had the appropriate supervision and it was believed that this was due to the lack of staff and inadequate educational structure.	Yes. Please see Ph. 1.3

	In the dispensary PRPs were required to complete 100 dispensing accuracy logs. They will also be required to check 100 items accurately in their last month of training. Training on this should be provided by the acting PRP EPD. These logs and completion of dispensary objectives in a workbook should be checked by the ES but this did not happen for all trainees. PSs were not sure of who signed trainees' competencies and where the progression logs were stored.	

GPhC Standard 2) Monitoring, review and evaluation of education and training

Standards

The quality of pharmacy education and training must be monitored, reviewed and evaluated in a systematic and developmental way. This includes the whole curriculum and timetable and evaluation of it

Stakeholder input into monitoring and evaluation

Trainees in difficulty and the Trainee in Difficulty policy

Ph. 2.1	**Educational governance** The visit team heard that the PTPT/ PRP EPD was currently on maternity leave and the education leadership was now shared between the deputy chief pharmacist and one principal pharmacist. The Trust had one NVQ internal quality assurance (IQA) person and was currently looking into training further assessors to assist with the delivery of PTPT training. The senior management reported that they worked closely with LPET and Buttercup. It was stated that PTPTs were given a workbook within which at least three objectives for each rotations were outlined. These objectives were believed to be signed off after each rotation by the training lead. All were documented and tracking reports were then discussed at standardisation meetings which took place two to three times a year. However, if it was identified that a trainee was struggling, then an emergency standardisation meeting would take place. Nonetheless, the visit team was informed that the PTPT training had no organised mechanism to ensure that PTPT trainees were receiving adequate training prior to undertaking assigned work and that the dispensary unit at St Helier Hospital only had a checklist system but no training manual was provided. Trainees reported that apart from within the pharmacy production unit and the medicine information department, training and educational needs were neither consistently assessed nor discussed.	Yes. Please see Ph. 2.1
Ph. 2.2	**Educational strategy** It was reported that the Trust had been experiencing some uncertainties due to a potential demerger of the ESHT. As a result, the pharmacy department had to keep adapting to the bigger strategic programme of the Trust and this had inadvertently affected the ability of the senior management of pharmacy to focus on the current training needs. The pharmacy store and distribution unit were based only at St Helier Hospital and the pharmacy production had recently been outsourced due to a fire incident in February 2016. The longer term provision of aseptic service provision was under review. However, the production practice supervisors reported that the fire incident had not affected service needs at the Trust and arrangements were being made for future trainees to receive pharmacy production training at St George's University Hospital in the interim. It was reported that meetings had taken place with regards to potentially outsourcing the outpatient dispensary function but no tangible strategies had been agreed yet. The senior management reported that they were still in discussion of how to implement the seven day service but had yet to develop a plan. The dispensary service was	Yes. Please see Ph. 2.2

	currently only opened on Saturday mornings and an enhanced service was being delivered to acute medicine on bank holidays only on a volunteering basis. The pharmacy staff were participating in wards huddles to facilitate and identify priorities for discharge. It was recognised that provision of TTOs could be a bottle neck and the project was highlighting the need for further work in this area. The pharmacy department recognised that it was finding it challenging to recruit and retain junior pharmacists.	
Ph. 2.3	**Local faculty groups** The visit team was informed that the pharmacy department was currently working towards the implementation of Local Faculty Group (LFG) meetings. The chief pharmacist and the EPDs met on a monthly basis to discuss educational needs and NVQ assessors also met regularly to discuss education and training. It was reported that there was a presence of senior management at each site so as meetings with trainees could be organised and managed easily. The visit team also heard that pharmacy was working alongside the LPET to support the delivery of PTPT training. Nonetheless, none of these meetings were being documented and neither was meeting with senior managers incorporated into trainees' rota.	Yes. Please see Ph. 2.3
GPhc Standard 3) Equality, diversity and fairness		
Standards **Pharmacy education and training must be based on the principles of equality, diversity and fairness. It must meet the needs of current legislation.**		
	No issues relating to equality, diversity or fairness were identified during the visit.	
GPhC Standard 4) Selection of trainees		
Standards **Selection processes must be open and fair and comply with relevant legislation**		
	This standard was not discussed during the visit.	
GPhC Standard 5) Curriculum delivery and trainee experience		
Standards **The local curriculum must be appropriate for national requirements. It must ensure that trainees and PG pharmacists practise safely and effectively. To ensure this, pass/ competence criteria must describe professional, safe and effective practice.** **This includes:** ☐ **The GPhC pre-reg performance standards, Pre-registration Trainee Pharmacist Handbook and local curricular response to them.** ☐ **Range of educational and practice activities as set out in the local curriculum.** ☐ **Access to training days, e-learning resources and other learning opportunities that form an intrinsic part of the training programme.**		
Ph. 5.1	**Rotas** The visit team heard from the senior management that the rota for the pre-registration pharmacists (PRPs) was mapped for the year in advance and the pre-registration	

	trainee pharmacy technicians' (PTPTs) rota was structured according to the National Vocational Qualification (NVQ) requirements. PRPs were given flexibility at the end of the year to have extra training if required. The pharmacy production rotation was described as well-structured prior to the fire incident whereby PTPTs spent four months within the production unit only and PRPs spent six weeks within the unit while undertaking clinical work as well. All trainees were allocated a base hospital and they undertake dispensary training at their base site. The St Helier dispensary is considerably busier but there are opportunities to work in over the counter sales at Epsom. The dispensary rotation for PRPs towards the end of the year was scheduled during the afternoons as it was described as a split rotation. All trainees at St Helier were listed to work one late night every week. Trainees based at Epsom did not undertake late night duties. The visit team heard that the Saturday rotations were planned so that a mixed skill-set was part of the team and this was scheduled significantly in advance. Nonetheless, trainees reported that they did not receive much training before commencing the out of hours dispensary rotation, especially at St Helier Hospital. The educational supervisors (ES) mentioned that trainees were scheduled to work out of hours within the dispensary unit only six weeks after starting the post. Trainees reported that although rotations were well structured, at times they would be moved into dispensary to accommodate for the increase in service needs. PTPT trainees felt that the dispensary rota within St Helier Hospital was driven by gaps within the rota or service. PRP trainees also reported that they felt one week rotations in different clinical areas were not sufficient for them to gain adequate education and training especially when no clear outlined objectives were set for trainees. The lack of staff meant that rotations were occasionally swapped around to accommodate and trainees were only given short notices of such changes. It was also communicated that a shortage of staff had at times led to the loss of training within a particular department.	
Ph. 5.2	**Induction** The visit team heard that inductions at ESHT were centrally structured at the Trust every year. The mandatory Trust inductions lasted two days and delivered core requirements; the pharmacy department delivered a specialty-focused induction over a period of two weeks across both hospitals. The senior management informed the visiting team that a Trust induction pack as well as a pharmacy induction pack was provided and a record of the completed induction logs was documented. However, it was not clear if trainees had appropriate induction within each department; practice supervisors (PSs) stated that the PTPTs' induction programme to the dispensary unit was personal to the trainees and there were a set of objectives listed for the year that had to be completed but it was not structured. It was also mentioned that as the PTPTs at the Trust were previous assistant technical officers (ATOs), it was believed that they had the basic knowledge of dispensary. The visit team heard that one of the PTPT trainees did not commence NVQ training with London Pharmacy Education and Training (LPET) until eight months after commencing their post. This was a 2 year programme that should be completed within that time frame. It was reported that all staff and trainees were allocated a buddy at the beginning of their posts within the Trust. This had been devised as an extended support from the Trust to new starters and the buddies' responsibilities were clearly outlined. Inductions for both trainee groups were reported as beneficial and robust.	Yes. Please see Ph. 5.2

Ph. 5.3	**Educational and training environment** The visit team was informed that trainees felt well supported within the renal, medicine information (MI) and pharmacy production units. The departments offered good training opportunities via their structured and compassionate approach. PRPs described their MI rotation as having helped with their confidence. These departments provided set objectives and trainees felt this helped enormously. However, trainees did not feel supported within the dispensary unit at St Helier Hospital and stated that they would not recommend this rotation to future trainees. Trainees felt that the dispensary unit at Epsom Hospital provided better support. PTPTs explained that the lack of an education structure within the dispensary unit demotivated them. The visit team heard that the resistance to change from permanent staff within the dispensary unit at St Helier Hospital hindered the breadth of experience the trainees were provided with. It was reported that there was no opportunities for trainees to raise concerns nor was there a feedback mechanism in place for shortcomings to be addressed. Trainees felt that locum pharmacists within the Trust were more supportive towards their education and training. It was stated that meetings at St Helier Hospital in the past had not been constructive and this did not help further the learning opportunities for trainees. This had improved this year. Trainees reported not being comfortable to feedback as they had not felt heard and supported when concerns had been raised in the past. The visit team heard that PTPTs had been requested to train PRPs after only conducting a task competently once before. ES reported that although there was no allocated time for learning, PTPTs received half a day per week for study. It was mentioned that PRPs did not have any protected study time but if the department was quiet, trainees were encouraged to go and study. The visit team heard that pharmacy trainees experienced a varying relationship with doctors and nurses at the Trust. It was felt that due to general unawareness of pharmacy processes, the department was seen as less important and trainees did not feel very confident working within such an environment.	Yes. Please see Ph. 5.3
Ph. 5.4	**Curriculum** Training packs were available for most rotations however it was reported that the “training packs for PTPTs” were out of date and need to be reviewed. The PRP training handbook is updated every year. **Dispensary** A training pack for the dispensary had been written but the majority of dispensaries PSs were not familiar with it. Within the dispensary training pack which had been provided to the visiting team there was reference to a Gold Standard however staff were not able to define that explicitly. **Production/ Technical Services** Due to the fire in the Production Unit, technical services training had to change responsively. 75% of PRPs had already undertaken their Technical services rotation at the time of the fire. The rotation was covered for the fourth by arranging a placement at St Georges Hospital plus a focus on the clinical application of aseptically prepared products at ESHT. This will be repeated for the new PRPs that commence training in August. The PTPTs had changed NVQ optional modules and production was replaced with medicines management. A decision on whether new PTPTs in future would undertake the optional NVQ aseptic unit has not been made. **Clinical/ medicines management** PRPs focus on being trained and becoming competent in medicines reconciliation early	Yes. Please see Ph.5.4

	in the year. Towards the end of the year they will be allocated their own bay or ward. PRPs will work through a clinical workbook. The ES is tasked to sign this off. PRPs reported that clinical training in renal was particularly good and well supported. PRPs reported that objectives were not set for rotations in gastroenterology, respiratory or the private ward.	
Ph. 5.5	**Trainee progress and assessment** Regular NVQ standardisation meetings were held to track PTPT progress. These were documented. These were supported by reports from Buttercups and LPET. If there was a trainee requiring additional support (TRAS), an emergency standardisation meeting would be called. It was understood that due to the lack of educational leadership within PTPT training, there was potential for a trainee to not complete his/her training in time and no contingency plan was yet in place to ensure that assessments and underpinning knowledge requirements by the curriculum were completed in time. Trainees were meant to keep a completed log of their objectives however it was unclear where these were stored.	Yes. Please see Ph. 5.5

GPhC Standard 6) Support and development for trainees

Standards

Trainees on any programme managed by the Pharmacy LFG must be supported to develop as learners and professionals. They must have regular on-going educational supervision with a timetable for supervision meetings. All LFGs must adhere to the HEEKSS Trainee in Difficulty policy and be able to show how this works in practice. LFGs must implement and monitor policies and incidents of grievance and discipline, bullying and harassment. All trainees should have the opportunity to learn from and with other health care professionals.

Ph. 6.1	**Academic opportunities/ study support** The visit team heard that PRPs were allowed time to undertake an audit as part of their PRP programme but this was run on a trainee-led basis. It was reported that PRPs had weekly lunchtime educational sessions based at Epsom Hospital; this meant that trainees based at St Helier were losing training time due to travelling between sites on that afternoon each week. PTPTs were allocated a half day/ week as study time. Trainees tended to use either the library or office within the pharmacy store on the Epsom site for studying.	
Ph. 6.2	**Feedback** The visit team heard that there were no outlined processes in place within the department for feedback on training to be provided. Feedback was treated as a self-directed culture and was provided verbally only. It was stated that casual conversations and training logs were used to gauge if learning objectives and set training standards were being met; however, PSs reported that they would welcome learner feedback forums or any other formal forums whereby feedback on training programmes could be provided in a structured manner. PTPT trainees, received assessment feedback in the guise of appraisal and end of unit assessment meetings. The pharmacy production department used an in-house training manual to provide constructive feedback to pharmacy trainees at the end of their rotation within the department. If there were serious concerns, ESs were notified. The production department also explained that they had a structure in place to review	

	training within the department. The senior management reported that the PRP/ PTPT EPD was working on a feedback structure prior to going on maternity leave but this had now been put on hold.	
Ph. 6.3	**Inter-professional multidisciplinary learning** The visit team heard that the deputy chief pharmacist was currently delivering training to foundation doctors. Pharmacy had previously devised a prescribing assessment for foundation year one trainees but was now using the regional one. Junior pharmacists were also enlisted to train nurses with intravenous medicine training. Pharmacy also contributed to the Trust Clinical Quality and Assurance Committee. However, PRPs reported that they felt there was a lack of multi-disciplinary collaboration, hence a loss of learning opportunity due to the culture.	
Ph. 6.4 6.5 6.6	**Educational supervision** It was reported that all PRP ESs met with their trainees as a group at the beginning of the year to set the ground rules. This was generally conducted during an afternoon. After this, ESs met with trainees every 13 weeks i.e. GPhC appraisals. PRP trainees reported meeting with their ES every 13 weeks but were aware that the ES were always available if they required help. PRPs also reported meeting with the acting pharmacist EPD every week during lunch time. The acting PTPT EPD regularly informally checked with PTPTs and their PSs that there are no issues. PTPTs reported that there was no such structure for them to formally meet with their ES and discuss their education and training. The visit team heard that the meetings were ad-hoc and the department worked on the basis that 'no news is good news'. When the trainees were rotating at their assigned hospital, the ESs liaised with the supervising pharmacists via email or telephone. There were no formal meetings but ESs reported having frequent informal conversations with their trainees. PTPT trainees, on the other hand only met with their ESs when they were being assessed and their progression was monitored by Buttercups and LPET who provide the underpinning knowledge training programme and assessments. Nonetheless, the senior management reported that Buttercups was not great at communicating and had to be chased for assessment results. **Practice Supervision** It was recognised that there had been a lack of support to manage trainees' progression with the dispensary; therefore the application of 'get right first time' support mechanism was being put in place. Practice supervision for PTPTs at St Helier Hospital had been poor but had improved considerably this year. Dispensary PRP PSs did not have scheduled meetings with trainees. Instead support was based on their day to day interaction. All PRPs have a named audit supervisor. This is always a different person to their educational supervisor. All PRPs have a PS when attached to a ward however these PSs can change as they rotate and therefore they are not always aware that they have a trainee coming to them. PS arrangements in Medicines Information and Production were well planned and very supportive. **Mentoring/ buddying** All trainees are allocated a mentor or buddy. The amount that these were used varied but they were considered valuable particularly at the start of the year.	

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

Standards

Anyone delivering initial education and training should be supported to develop in their professional role

Ph. 7.1	**Professional development** All PRP ESs had completed the LPET new Tutor training course. Some had also attended bespoke educational recap days and supporting trainees in difficulty. Technical services PSs had experience in an ES capacity but had not attended formal training for the PS role. The visit team did not hear of any appraisal process in place at the Trust for trainers that specifically included the educational role within it. PSs reported that most of their supervising experience was derived from their own working experiences as they had not received any external training. PSs within the production department had done the Buttercup's assessor training.	

GPhC Standard 8) Management of initial education and training

Standards

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

	Accountability and responsibility for pharmacy education The EPD is currently on maternity leave and this post would be responsible for both PRP and PTPT training. At the moment PTPT training is being managed by the Deputy Chief Pharmacist with support from the Dispensary Manager at St Helier Hospital. The EPD reports to the Deputy Chief Pharmacist.	

GPhC Standard 9) Resources and capacity

Standards

Resources and capacity are sufficient to deliver outcomes

Ph. 9.1	**Information technology** It was reported that the IT services within the Trust did not work efficiently and as a result learning opportunities were being lost. Although there were video conferencing facilities, these were reported to be unreliable. This meant that trainees were spending time travelling between sites for meetings or training sessions that could potentially be carried out via VC. One of the new PTPT education providers use on line live streaming of teaching and there was concern that the Trust IT would not be sufficient to support this.	
Ph. 9.2	**Staff resources** Backfill for maternity cover of the EPD had not been funded within the Trust.	
Ph. 9.3	**Finance** The pharmacy senior management team stated that they may need more PTPTs in future but as these posts are only part funded by HEE, it was difficult to secure Trust funding to train more. This had also led to uncertainty about whether the trust would be filling the allocated PTPT commissions for 2016/17	

GPhC Standard 10) Outcomes		
Standards **Outcomes for the initial education and training of pharmacists**		
Ph. 10.1	**Registration and pass rates** **Retention** Pharmacy technician turnover was low but PTPTs could usually be retained into pharmacy technician posts. One of four PRPs was being retained as a Band 6 pharmacist upon registration this year. **Registration** Pass and registration rates had been very high and above the regional average in the previous three years.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The buddying scheme was a good initiative particularly during the induction period.	Jill Stevens	Please complete the attached pro forma and return to the Quality and Regulation Team at Health Education England.	10 August 2016
Practice supervision in medicines information, production and renal medicine was commended by trainees for being so supportive. This should be shared within the department	Jill Stevens	Please complete the attached pro forma and return to the Quality and Regulation Team at Health Education England.	10 August 2016

Mandatory Requirements		
Req. Ref No.	**Requirement**	**Required Actions / Evidence**
Ph. 5.5	The department should develop a policy or procedure for identifying trainees requiring additional support or extensions in a timely manner which includes escalation	A policy/ procedure to be submitted by 1/10/16
Ph. 1.1, 1.3, 2.1, 5.4	An updated training and assessment pack for PTPTs and PRPs for dispensary rotations should be produced. This should also set out where dispensary training records are held.	A new dispensary training pack should be submitted by 1/10/16
Ph. 1.1, 1.3	Procedures should ensure that trainees do not work more than six hours without a break and adequate supervision arrangements are in place at all times especially late night duties	Confirmation from the Trust that this has been reviewed and actions put in place to avoid this in future
Ph. 2.3,	A Pharmacy Local Faculty Group to be	Local Faculty Group minutes and terms of reference to

5.3	established which meets quarterly. First meeting to have taken place by 1/10/16.	be submitted within one month of each meeting for the next 12 months. An LFG annual review to be conducted and submitted by 31/3/17.
Ph. 6.4	All PRPs should have monthly scheduled and documented meetings with their tutors/ ES	Confirmation that this is in place by 1/10/16. This will be reviewed via regional exit surveys for preregistration trainees
Ph. 9.3	Confirmation of numbers of PTPTs to commence training in 2016/17 and which education provider will be used	To be provided to HEE by 31/7/16

Recommendations

Req. Ref No.	Recommendation
Ph. 2.2, 5.2, 5.5, 9.3	The department should develop leadership for PTPT training so that there is one named member of staff responsible for ensuring the quality of training, delivery of curriculum, progress of trainees and the development and delivery of future training taking into account the new education provider arrangements, regulatory changes to the qualification etc and that adequate time is built into the role.
Ph. 2.2, 9.3	Pharmacy should be aware of the Trust educational strategy and develop its own departmental education strategy linked to this and national policies. This strategy should inform trainee curricula and numbers
Ph. 6.3	There should be an organisational multi-professional learning strategy; Pharmacy trainees should take part in at least multi-professional learning event within the next year.
Ph. 9.1	Videoconferencing facilities and other IT solutions should be developed to support learning and reduce travelling between sites
Ph. 5.3	Trainee representatives should be identified and trained to participate in the Pharmacy LFG
Ph. 5.4	Practice supervision in gastroenterology and respiratory should be reviewed to ensure practice supervisors are trained, objectives set and progress review established.
Ph. 2.2	Future contracts for outsourcing outpatient dispensing should include requirements in relation to preregistration training and supervision.

Other Actions (including actions to be taken by Health Education England)

Requirement	Responsibility

Signed

By the Lead Visitor on behalf of the Visiting Team:	Gail Fleming, Head of Pharmacy, Health Education England London and South East
Date:	27 July 2016