Developing the Healthcare Workforce

Workforce issues and principles for Pharmacy

1. Pharmacists are a national resource with educational requirements that must meet national and international standards and which, for all pharmacists, must be rooted in a deep understanding of science and evidence based healthcare.

2. Two thirds of pharmacists work in the community these pharmacists are not employed by the NHS, however do perform essential NHS activities.

3. High quality education requires national coordination and regulation. Pharmacy education is a continuum from the undergraduate level to retirement, overseen by the GPhC, involving community and hospital settings and NHS and private providers. Pharmacy schools need to be true partners of NHS and private healthcare providers and commissioners in primary and secondary care - designing new systems together and preparing pharmacists for the myriad of ever-changing roles required of them.

4. Funding for pharmacy education and training must be ring fenced and allocated transparently and in sufficient volume to meet the requirements of the numbers commissioned centrally. Decisions about the numbers of pharmacists needed cannot be left to local Skills Networks, national oversight and coordination is required. Improving the quality and safety of primary and secondary healthcare, delivering the self-care and public health agendas, and secondary care specialisations all require effective pharmacists.

5. The proposed Skills Networks and role need to be better defined, as does how these new structures will relate to existing structures.

6. Any infrastructure for managing and assuring the quality of workplace-based pharmacy training must provide clear accountability and responsibility for delivery of quality teaching, learning and assessment. This infrastructure must include employer representation and commitment from hospital and community pharmacy and possibly industry, be in partnership with pharmacy schools and properly resourced.

7. Multi-professional oversight of the workforce such as through HEE must be accompanied by single professional oversight, such as currently facilitated by the programme boards.

8. Inter-professional education, when used appropriately enhances effective team working. It can be of particular benefit when applied to certain areas of learning such as prescribing, patient safety, and clinical leadership.

9. Clinical and related scientific academia is of vital importance to UK plc and is threatened by current developments. For example the NHS Outcomes Framework requires no commitment to research and education; and the move to focus on local issues will endanger the bigger picture. Without clinical academics and those in the supporting sciences; innovation, quality, efficiency and productivity will stall.

10. To minimise any negative impact on widening participation pharmacy should be included in the NHS bursary scheme. Clarity about the future provision of NHS bursaries is therefore required.

We welcome consultation on these important proposals and especially welcome recognition and inclusion of pharmacy.

Purpose and Scope

Q1: Are these the right high-level objectives? If not, why not?

CUHOP is supportive of the high-level objectives outlined as long as equity of access to high quality care is maintained for patients across the UK. To ensure that access to high quality care is maintained, it is important that any new infrastructure includes national and UK-wide oversight, as there is a very significant danger that GP consortia will not appreciate the complexity of educational requirements or consider implications for the longer term in their planning.

<u>Security of Supply</u>

We agree that there is a need to prioritise security of supply of appropriately skilled staff. Indeed for pharmacy there is a danger of market mechanisms failing. Ensuring transition from graduation to registration with the GPhC is essential. Under the current system, this requires the provision of an appropriate number of pre-registration placements for the number of pharmacy graduates.

Any workforce planning needs to encompass the full range of pharmacy roles with almost two thirds working in the community for multiples and independent providers, and almost a third in NHS Hospitals and Primary Care Organisations. Pharmacists are essential to delivering the self-care and public health agendas, and secondary care specialisations. In addition a small number of pharmacists work in industry and academia both on a full time and part time basis.

Any decisions made in England about the numbers of new healthcare professionals required, need to be considered with the devolved nations.

<u>Responsiveness and High Quality Education Training</u>

Pharmacy education and training must prepare students and trainees for a wide range of career pathways, and the fast developing healthcare landscape. In order to deliver high quality training and to achieve responsiveness to patient needs and changing service models NHS colleagues in primary and secondary care together with leaders from the community pharmacy sector and the

pharmaceutical industry must be true partners of pharmacy schools, designing new systems together and preparing pharmacists for the myriad of ever-changing roles required of them.

Value for Money

It should be recognised that the best value for money option is not always the same as the cheapest option. Care must be taken that appropriate investment in education and training is made to help avoid unintended costs later. We are supportive of a system that promotes transparent and secure funding for education and training.

Widening Participation

The recent MPC discussion paper: *Review of pharmacist undergraduate education and pre-registration training and proposals for reform* proposes a five-year MPharm programme with integrated clinical placements; improving the attractiveness of studying pharmacy generally with expectation that it would also support the widening access agenda. However, the longer undergraduate programme and the potential loss of a year's earning may also have a negative impact on widening participation in pharmacy. To minimise any negative impact on widening participation the MPC discussion paper suggests the inclusion of pharmacy in the NHS bursary scheme. Clarity about the future provision of NHS bursaries, particularly in relation to pharmacy is therefore required.

Vision

Q2: Are these the right design principles? If not, why not?

Broadly speaking CUHOP is supportive of the outlined design principles. We recognise the need for an approach to workforce planning that considers the contributions of all professions together, described in the principles as a 'multi professional' approach. However we would warn against an approach that failed to distinguish the unique contributions of the different health professions or served to devalue any single professional group.

Considerable thought needs to be given to the local, regional and national levels of governance to ensure there is the right balance between local flexibility and equity of quality and access at a national level.

We would endorse the need for professional engagement in and leadership of quality and safety in health education and training, whilst recognising the need for external assurance and regulation. In Pharmacy this would be the role of the GPhC. We would add that many of those best placed to deliver the required professional leadership required are clinical academics and those in the related sciences, who have a unique and valuable position of being involved in the delivery of healthcare and health education, and being at the forefront of bioscience and healthcare research. It is essential that academics, educationalists, healthcare professionals and employers work together to create programmes that will be proper foundations for entire careers and which take account of patients' requirements and the need to embrace scientific advances and innovation in healthcare.

Context

Q3: In developing the new system, what are the key strengths of the existing arrangements that we need to build on?

Strengths of the current system include the national and UK wide bodies such as UKHEAC, HENSE, the Programme Boards within MEE and the overview provided by MEE itself. It is vital that there is the greatest clarity on the accountabilities between the proposed HEE and skills networks for managing the levy, and to ensure that HENSE is maintained and its role enhanced. The current system also provides the opportunity for widespread involvement in research and clinical trials through ring-fenced funding for research through NIHR.

A key strength of the current system is the quality of the healthcare workers produced in England and the rest of the UK. Pharmacists are a national resource with educational requirements that must meet national and international standards and which, for all pharmacists, must be rooted in a deep understanding of science. It should be recognised that pharmacists are an integral part of the healthcare workforce in the community, in hospitals, in industry as well as through their involvement in public health. Pharmacists, opticians and dentists in the community should not be viewed or treated as peripheral; these professionals are numerically important for workforce planning and contribute greatly to patient care and public health.

Furthermore the UK currently benefits from the ability to generate wealth from the delivery of high quality healthcare education and training to overseas students. In pharmacy the numbers of overseas students represent a significant minority and it is important that this source of talent, diversity and funding for teaching and infrastructure be maintained.

Q4: What are the key opportunities in developing a new approach?

Developing a new approach creates the opportunity to:

- Develop true partnerships between universities and healthcare providers and other areas of pharmacy
- Ring-fence the funds for education and to use them transparently to maintain quality
- Reach consensus on the roles of the different healthcare professions
- Ensure a smoother transition from undergraduate to postgraduate training
- Re-structure initial pharmacy training to deliver integrated programmes, which lead to registration with the GPhC and that incorporate significant hospital and community placements
- Enhance opportunities to quality assure placements and to optimise pharmacy education and training through collaboration between pharmacy schools, the GPhC and pharmacy professional leadership bodies such as the Royal Pharmaceutical Society, the UK Clinical Pharmacy Association and CUHOP.
- Develop education and training that promotes inter-professional working within an integrated healthcare system.
- Develop a simpler and more uniform funding stream for all healthcare professionals, defining their role within the healthcare system and funding their education appropriately to achieve these.

Developing a new system

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"Much of the detail will need to be worked through …" is rather an understatement. There are significant risks in implementing these proposals.

Increased autonomy and accountability for healthcare providers

Q5: Should all healthcare providers have a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop the healthcare workforce?

We would agree that it is important to consult patients *and* to take action on the basis of their responses. It should be recognised that healthcare providers also include plcs and private equity companies in the community pharmacy sector.

Q6: Should healthcare providers have a duty to provide data about their current workforce?

We agree that healthcare providers should provide data about the current workforce. These data must be accurate with a clear indication as to whether they refer to headcounts or full time equivalents. Again, the private sector and otherwise independent employers must also be involved.

Q7: Should healthcare providers have a duty to provide data on their future workforce needs?

We agree that all healthcare providers (again including private and independent employers) should have a duty to provide data on their future workforce needs. In addition the Centre for Workforce Intelligence working on behalf of HEE should seek to develop long term plans based on realistic estimates.

Q8: Should healthcare providers have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training?

We also agree that all healthcare providers (again including private and independent employers) should have a duty to cooperate on planning the healthcare workforce and planning and providing professional education and training. However one should be realistic about the extent to which small providers need to be involved in the planning process. Providers of both service and education should work together to draw up realistic workforce plans reflecting integrated care pathways for patients.

Q9: Are there other or different functions that healthcare providers working together would need to provide?

CUHOP welcomes the suggestion of a multi-professional approach, with the inclusion of Pharmacy, to managing the provision of undergraduate clinical placements and pre- and post-registration training. Healthcare providers and education providers should work together to provide data reflecting the quality of placements in order to assess, enhance and assure the quality of placements. Providers must meet agreed targets and respond promptly and effectively to rectify poor quality placements.

Q10: Should all healthcare providers be expected to work within a local networking arrangement?

In order to optimise the training opportunities available, all healthcare providers should be expected to work within a local networking arrangement, and there should be penalties for non-cooperation. However, consideration of the barriers to cooperation is needed, for example the requirement to create a new legal entity, which has proved very complex and costly for the providers that have already done so. Local networks should work together to provide economies of scale and to reduce transactional costs.

Q11: Do these duties provide the right foundation for healthcare providers to take on greater ownership and responsibility for planning and developing the healthcare workforce?

The duties listed above lack sufficient detail to guarantee effective coordination and delivery of the education and training of the healthcare professions. We agree that healthcare providers need to work in partnership with the HEIs to develop long term, sustainable plans. However there is little mention in the consultation of how such relationships with HEIs will be promoted and sustained, and indeed only one consultation question even mentions undergraduates. In defining the roles and responsibilities for commissioning and delivering education and training it is essential that:

- Universities are made real partners in the planning and development of the healthcare workforce
- Funding of the quality management processes and the power to withdraw salary funding from poor quality placements is held separately from the provider network

In establishing the Skills Networks it will be essential to build on existing local partnerships established through AHSCs, BRCs and BRUs, HIECs and CLAHRCs.

We do welcome the opportunity for a stronger multi-professional approach to postgraduate education and training presented by the healthcare provider skills networks. In doing so it will be important to build on what works and is retained from the current system by enhancing current governance structures; for example by integrating a pharmacy dean into the existing deaneries.

Q12: Are there other incentives and ways in which we could ensure that there is an appropriate degree of cooperation, coherence and consultation in the system?

There must be a legal obligation on all providers both to pay the education levy and to engage actively in educating and training both the current and the future workforce. There should be no option that allows payment of a levy without also participation in teaching. There needs to be clear financial penalties for non-compliance. Further work needs to be undertaken to develop measures that accurately reflect the quality of a placement.

Sector wide oversight and support in developing the future workforce

Q13: Are these the right functions that should be assigned to the Health Education England Board?

The four broad functions proposed for HEE are, in the main, appropriate. However, whilst it may only be concerned with the allocation of *NHS* funding, HEE and related structures must consider, and

work closely with the community pharmacy sector, industry and academia: this is of particular importance for pharmacy. Also in allocating the resources for NHS Education and Training, the Quality Assurance function and its linked funding stream must lie outside the provider networks, for example within multi-professional post-graduate deanery functions attached to universities.

Funds will need to be retained centrally for those activities which still need to be undertaken nationally for example:

- HEE should hold the contract for the Centre for Workforce Intelligence
- Guided by what employers say they need, HEE should recommend to HEFCE student numbers for pharmacy working in concert with colleagues across the UK – in doing so it will be essential for HEE to take a long term view to workforce planning
- HEE should have the power to act and intervene when local workforce planning undermines national interests
- HEE should work through Programme Boards to facilitate employer involvement in curriculum development and to ensure curricula are relevant and deliverable across the UK
- The Pharmacy Programme Board should be retained

In order to ensure true professional leadership, there need to be places for elected representatives of the professions on Programme Boards and HEE.

Q14: How should the accountability framework between healthcare provider skills networks and HEE be developed?

Accountability requires that robust quality assurance mechanisms with the power to impose significant financial penalties be created in order to protect the investment in education and training and to drive up standards. Quality assurance for pharmacy education and training needs to build on current HEI QA frameworks and THE General Pharmaceutical Council (GPhC) standards for pharmacy tutors and premises. See Q40.

Q15: How do we ensure the right checks and balances throughout all levels of the system?

The GPhC as the regulator of pharmacy education will continue to play a central role in quality assurance and for the benefit of patients. The pharmacy professional leadership bodies, including the Pharmacy Programme Board under the aegis of HEE will play a central role in curriculum development in concert with individual HEIs. Effective partnerships between education and service need to be fostered with external, independent quality assurance of activities. HEE must be given 'teeth' with the right to call on the NHS Commissioning Board for support if local plans cannot be accommodated within national requirements.

Q16: How should the governance of HEE be established so that it has the confidence of the public, professions, healthcare providers, commissioners of services and higher education institutions?

The Chair of HEE should be a highly regarded senior clinical academic with recent experience of healthcare education. HEE should have a small board which includes non-executive directors with a

clinical academic background. The Chief Pharmaceutical Officer (CPO) should sit on both HEE and the NHS Commissioning Board. The programme boards should be maintained, pharmacy is largely unique in its level of interactions with private providers, this introduces a layer of complexity to the development of the pharmacy workforce that needs to be considered at a national level.

In creating the governance structures account should be taken of the systems in place in the other 3 nations.

Q17: How do we ensure that the Centre for Workforce Intelligence is effective in improving the evidence base for workforce planning and supports both local healthcare providers and HEE?

The CfWI should take time to ensure that it has accurately determined the nature of the information it is seeking to collect from employers and must require that the data be presented to it in a consistent manner to facilitate accurate and effective analysis. It would also be advisable for the CfWI to work with the professional regulators, which hold varying levels of data; in some cases it may be appropriate to provide funding to support a regulator to enhance its own data collection.

When considering 'cross-boundary flows' thought must be given to movement within the UK and into the UK from elsewhere. The former requires cooperation between the administrations. In terms of the latter a distinction needs to be made between those from outside of the UK who are trained here and those that are fully qualified. Pharmacy education in HEIs is significantly subsidised by overseas student tuition fee income and for decades many such students have entered the UK pharmacy workforce, at least for early years' experience and professional development, as highly capable practitioners. This has been good for them, good for the NHS, good for universities and the UK economy. When there is a need to 'import' healthcare practitioners it is far better that they be from this source rather than qualified practitioners trained overseas.

Q18: How should we ensure that sector-wide education and training plans are responsive to the strategic commissioning intentions of the NHS Commissioning Board?

The CPO should sit on both HEE and the NHS Commissioning Board. The Chair of HENSE should work closely with HEE.

Q19: Who should have responsibility for enforcing the duties on providers in relation to consultation, the provision of workforce information, and cooperation in planning the workforce and in the planning and provision of professional education and training?

We believe that HEE should have the responsibility for enforcing duties on providers with financial penalties to enforce compliance. To support HEE in this endeavour the regulators of the healthcare professions (including GPhC), CQC and Monitor must inform HEE of concerns they have picked up.

Q20: What support should Skills for Health offer healthcare providers during transition?

The suggestion that it supports smaller providers seems sensible.

Q21: What is the role for a sector skills council in the new framework?

There does not appear to be a role for the sector skills council in the new framework.

Q22: How can the healthcare provider skills networks and HEE best secure clinical leadership locally and nationally?

To secure clinical leadership nationally and locally HEE and local skills networks will need to work with professional leadership bodies such as Royal Pharmaceutical Society (RPS), UKCPA and CUHOP nationally as well as HEIs locally.

Q23: In developing the new system, what are the responsibilities that need to be in place for the development of leadership and management skills amongst professionals?

We welcome the DH's recognition of the expertise and strategic role of CUHOP and similar HE organisations. Effective leadership and management are vital, which is recognised in the competencies expected of healthcare professionals by the regulators such as the GPhC. Pharmacy Schools are supportive of and engaged with the CCLF framework.

Q24: Should HEE have responsibilities for the leadership development framework for managers as well as clinicians?

It is important for colleagues to understand the demands of others' activities and so it would be reasonable for HEE to be accountable for the framework of leadership development across all leaders in healthcare – if it is given the capacity and additional funding to undertake this.

Q25: What are the key opportunities for developing clinicians and managers in an integrated way both across health and social care and across undergraduate and postgraduate programmes?

We are supportive of inter-professional education as a tool to enhance team working, however it needs to be delivered appropriately for the stage in training with sensitivity for and understanding of the unique roles and requirements of the individual professions. Inter-professional learning for areas of the curriculum such as leadership and management and for team building is important and should be developed in an expanding continuum across the whole of healthcare education.

Public Health Workforce

Q26: How should Public Health England, and its partners in public health delivery, be integrated within the new framework for planning and developing the healthcare workforce?

The extensive structural reforms proposed for public healthcare are a possible distraction from the primary objective of implementing strategies that directly improve population health. The proposed move of Public Health to local authorities means that LAs will have to ensure that the next generation of public health professionals is trained and thus they will need to have some close interaction with healthcare provider skills networks.

Furthermore pharmacy and pharmacy education and training must not be overlooked in the development of public health.

Q27: Should Local Authorities become members of the healthcare provider skills network arrangements, including their associated responsibilities; and what funding mechanisms should be employed with regard to the public health workforce?

Care needs to be taken not to make Skills Networks too large and therefore unmanageable; however skills networks will need to work closely with public health and social care

Funding and incentives to support equity and excellence

Q28: What are the key issues that need to be addressed to enable a strategic, provider-led and multi-professional approach to funding education and training, which drives excellence, equity and value for money?

Ring fence the funds so that they are spent only on education, and ensure that quality measures are in place to deliver excellence in education and training.

Take forward new initiatives on the basis of evidence. In turn this means ensuring that where existing research is not sufficient to answer questions these initiatives are properly consulted on, piloted and evaluated.

Health care providers to work in partnership with HEIs to co-develop programmes that make a clear distinction between training and the provision of care. The role of the professional regulators is also crucial in this.

Community providers need to be more open about their pharmacist workforce requirements for training to continue to be supported through the Community Pharmacy Contractual Framework. We emphasise again the importance of understanding the whole pharmacist workforce and not just those employed by the NHS. Whilst providing NHS pharmaceutical services, the majority of pharmacists are neither NHS contractors nor NHS employees throughout their professional careers.

Q29: What should be the scope for central investment through the Multi-Professional Education and Training budget?

MPET funding should include postgraduate education and training of NHS-employed pharmacists for their basic clinical roles. We would welcome 'some flexibility to support the development of new roles and advanced practice'; there is likely to be a need for such in pharmacy.

Q30: How can we ensure funding streams do not act as a disincentive to innovation and are able to support changes in skill mix?

Closer partnership working with universities will facilitate an evidence based approach and ensure that quality enhancement is delivered.

Q31: How can we manage the transition to tariffs for clinical education and training in a way that provides stability, is fair and minimises the risks to providers?

Adopt the system used widely internationally and pay a premium to university hospitals that recognises the additional cost of specialist services and of providing the correct environment for

research and education. In pharmacy, there is a need to fund the development of a proportion of community pharmacies as training practices, subject to appropriate quality assurance.

Q32: If tariffs are introduced, should the determination of the costs and tariffs for education and training be part of the same framework as service tariffs?

It is unlikely that the price paid will reflect the actual cost – but it needs to be a fair and realistic sum that is reviewed regularly.

Despite the lack of transparency, high quality education is currently provided. If MPET accounts for 5% of current expenditure, a 5% levy could be raised against the expenditure of all providers.

Q33: Are there alternative ways to determine the education and training tariffs other than based on the average national cost?

The recent MPET review demonstrated that the actual cost of delivering education and training to the healthcare workforce was greater than the funds available and so the tariff would not be able to provide the average national cost unless the funding stream was increased – which we would welcome. However since this does not seem likely, there seems little point in conducting further analysis, given also that the most recent review had already been scheduled for implementation this year.

Q34: Are there alternative ways to determine these costs other than by a detailed bottom-up costing exercise?

Nothing to add.

Q35: What is the appropriate pace to progress a levy?

Perhaps penalties through a top slice on MPET (to go back into the skills network for redistribution) for those that fail to engage with education and training and fail to deliver high quality placements would be a better way to proceed initially.

Q36: Which organisations should be covered by the levy? Should it include healthcare providers that do not provide services to the NHS but deliver their services using staff trained by the public purse?

We believe that all providers, including the private sector should be covered by the levy. However it is noted that community pharmacy contractors and employers such as Boots and Lloyds may argue that they pay towards this public good already in corporation and other taxes.

Q37: How should a levy be structured so that it gives the right incentives for investment in education and training in the public interest?

See Q 35

Q38: How can we introduce greater transparency in the short to medium term?

Training outcomes should be published, using established quality indicators. Universities will need to publish key information sets on their undergraduate courses and the regulator also publish the outcomes of quality assurance visits.

Q39: How can transaction costs of the new system be minimised?

By imposing minimum sizes (similar to those of current SHAs) on the networks commissioning services. If adopted, the role that HIECs and SHAs have in introducing research innovation should not be sidelined by the new need to deal with more operational educational issues.

Q40: What are the key quality metrics for education and training?

There are currently no agreed key quality metrics for pharmacy education and training. As pharmacy education and training is subject to the QAA *Code of practice for the assurance of academic quality and standards in higher education* and the GPhC requirements for initial pharmacy education and training, any quality metrics would need to be developed in line with and with reference to these standards and requirements. As a national (UK-wide) body for pharmacy education policy CUHOP is well placed to develop, in consultation with the GPhC and HEE, a set of agreed quality metrics for pharmacy education and training.

Transition arrangements

Q41: What are the challenges of transition?

It is absolutely crucial that this be an evolving process, with a long term view to workforce planning rather than a short term reactionary on. Where possible existing structures should incorporated and developed in to the new system. Throughout transition, risks should be identified and managed and transparency maintained.

Q42: What impact will the proposals have on staff who work in the current system?

There is certainly the potential for disengagement and loss of expertise during the next few months of uncertainty. However the proposals also bring the chance to re-invigorate healthcare professional training by establishing a true partnership between healthcare providers on the one hand and HEIs and postgraduate deaneries on the other. By ensuring that money follows the students and pre-registration trainees in a transparent way for educational purposes, unencumbered by service issues, real improvements in quality can be achieved, and health care providers will have a much greater stake in ensuring the success of this. As a result, newly registered pharmacists should be better prepared for practice.

Q43: What support systems might they need?

Essential support systems will involve:

- Adequate funding
- Clear lines of accountability and responsibility.

Q44: What support should the Centre for Workforce Intelligence provide to enable a smooth transition?

As a nascent organisation it is not yet in a position to facilitate a smooth transition. We anticipate that much greater resource will be necessary to supply the information required by many new skills networks.

Equality and diversity

Q45: Will these proposals meet these aims and enable the development of a more diverse workforce?

We would reiterate the need to consider and clarify the future of NHS Bursaries.

Q46: Do you think any groups or individuals (including those of different age, ethnic groups, sexual orientation, gender, gender identity (including transgender people), religions or belief; pregnant women, people who are married or in a civil partnership, or disabled people) will be advantaged or disadvantaged by these proposals or have greater difficulties than others in taking part in them? If so, what should be done to address these difficulties to remove the disadvantage?

See Q 45