Enabling a sustainable supply of pharmacy graduates: Proposals for consultation (first stage) (HEFCE 2013/19)

Annex B: **Response form**

Completed response forms should be e-mailed as an attachment to pharmacy@hefce.ac.uk by **1700 on Friday 15 November 2013**.

Analysis of responses

HEE and HEFCE will commit to read, record and analyse the views of every response to this consultation in a consistent manner. For reasons of practicality, usually a fair and balanced summary of responses rather than the individual responses themselves will inform any decision made. In most cases the merit of arguments made is likely to be given more weight than the number of times the same point is made. Responses from organisations or representative bodies which have high relevance or interest in the area under consultation, or are likely to be affected most by the proposals, are likely to carry more weight than those with little or none.

We will publish an analysis of the consultation responses and an explanation of how they were considered in our subsequent decision. Where we have not been able to respond to a significant and material issue raised, we will usually explain the reasons for this.

Freedom of information Act 2000

Information provided in response to a request, invitation or consultation from HEFCE or HEE may be made public, under the terms of the Freedom of Information Act or of an appropriate licence, or through another arrangement. Such information includes text, data and datasets. The Freedom of information Act gives a public right of access to any information held by a public authority defined within the Act, in this case HEFCE or HEE. It applies to information provided by individuals and organisations, for example universities and colleges. HEFCE or HEE can refuse to make such information available only in exceptional circumstances. This means that data and information are unlikely to be treated as confidential except in very particular circumstances. Further information about the Act is available at www.ico.org.uk.

Text boxes can be expanded to the required length.

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Allowing the market to determine outcomes

<u>Question 1</u>: What would be the impact of this approach upon patients, students, employers, universities and other stakeholders? Please address each in turn.

Patients: It is possible, initially, that a free market may lead to the best students becoming pharmacists and help to prevent the less able from becoming registered. However, there is a risk that the best students with the most appropriate knowledge, attitudes and skills will be deterred from applying to the profession if there is no guarantee of registration. This will be to the detriment of future patient care. It is important that discussions regarding the supply of future MPharm graduates are centred on maintaining and developing the quality of the profession so it is able to meet the likely increasing future demands that will be placed on it. The high, and probably increasing, numbers of students within this approach would mean there would be neither the capacity nor resources to provide placements during the undergraduate programme, thereby leading to students with less ability or opportunity to contextualise their learning. This too may impact upon the quality of care for patients.

Students: The expectation of students is currently that they will be able to register and practise as a pharmacist upon completion of their training. This expectation would need to change and be managed with a recognition that completion of a pharmacy degree would not necessarily lead to pre-registration training or qualification as a pharmacist, this is in contrast to other healthcare professional courses like medicine and dentistry.

Pharmacy degrees currently cost £9000 pa in fees, and, along with the maintenance component of the loan, students may incur debts of over £50,000 before graduating with an MPharm. 'Securing the student interest' is stated as a key factor in David Willett's letter to HEFCE. A BPSA study of the 2012/13 entrants onto English MPharm degrees indicated that the overwhelming majority expected to go on to practise as pharmacists.

Employers: It is difficult to predict. In the short-term employers should be able to select the best graduates to employ. However there is a risk that the overall quality could decrease over time as school leavers recognise that a pharmacy degree is no longer associated with good employment prospects.

Universities It is difficult to predict exactly how the sector could be affected by this, but it could become destabilised. In the short-term however, a free market is likely to be an attractive option for some universities as it is currently easy to attract high applicant numbers to pharmacy degrees. This option has an advantage in that it will be simple to implement due to maintaining the status quo. The implementation of this could, in the future, have many consequences, one of which could lead to a quality-driven selection process. However, if the inability of many graduates to complete their pharmacy education, along with poorer long term career prospects becomes widely appreciated by applicants, it is possible that within a short period MPharm courses across the board may struggle to fill places even with lower achieving applicants. There is no evidence to suggest that this would happen in only one particular type of institution. The Pharmacy Schools Council (PhSC) would consequently need to (in the long-term) work with the wider health service to consider the development of alternative career routes for pharmacy graduates and ensure that the wide skill-sets of graduates are realised in supporting the health and well-being of patients.

Others: It is possible that the oversupply of highly knowledgeable pharmacy graduates could be used to fill other health related roles within the NHS. It is important to highlight that pharmacy technician roles are now regulated and the possibility for unemployed graduates to fast track into a new higher-level technical role could be explored.

Currently the NHS/HEE funds all pre-registration places in England and if the number of such posts increases, it would result in a substantial growth in costs to the NHS budget. This is likely to be viewed as unacceptable in a period of austerity and when considered alongside the range of other competing costs of providing healthcare services for the NHS.

Question 2: What additional information could be provided to prospective students about the opportunities for completing registration as a pharmacist, and how could current information channels be improved?

Currently, there is an expectation that MPharm students will, and would like to, qualify as fully trained pharmacists once completing the MPharm degree. If the free market is retained and numbers continue to grow, there will be no certainly that students will be able to secure an NHS funded pre-registration place after graduation and become professionally qualified. This could impact on the desirability of the MPharm degree given the increased costs of higher education.

The recent Centre for Workforce Intelligence (CfWI) report into pharmacy indicates that there is likely to be a surplus of pharmacists in the near future if current trends continue, with much poorer employment prospects for the newly qualified. In this scenario universities would need to manage expectations appropriately to ensure that students were aware of the risk given that 'securing the student interest' is stated as a key factor in David Willett's letter to HEFCE.

The PhSC would suggest that were this option pursued, there is a need for the sector to work together to ensure that the unique skills-set gained by an MPharm student is recognised by industry, this includes robust scientific knowledge, coupled with an intricate knowledge of care that is focused on the individual needs of a patient. Technological developments mean these skills-sets are likely to become ever more valued, potentially increasing the employability of future MPharm graduates. In addition to working with employers, it is important to support MPharm students to understand the variety of careers available to them so they feel able to apply for a range of roles within the science and technology sector. In this context, significant changes in curriculum and emphasis may be required to accommodate such a change in future employment.

Introducing an intake control at each institution for entrants to pharmacy programmes

Question 3: What would be the impact of this approach upon patients, students, employers, universities and other stakeholders? Please address each in turn.

Patients: Workforce planning is very difficult and the NHS has previously failed to accurately estimate its workforce needs. If the predictions are wrong, it is possible that there could be another future undersupply in the long term. The importance of putting adequate time and investment into robust workforce planning is paramount to ensure that patients can access high quality pharmacy services. The CfWI recently completed a very detailed study of pharmacy

workforce needs in England, and this could be used as the basis of future planning. The recent report of the Commission on Future Models of Care Delivered through Pharmacy: '*Now or Never: Shaping Pharmacy for the Future*, proposes an extended role for pharmacists in order to ensure that patients receive the very best support.

Students: Managing numbers could mean that before committing to a loan to undertake pharmacy education, students would have a degree of reassurance that, if they succeed on the course, they can move on to become a pharmacist. The ability to focus resources on a consistent and managed number of students could help enhance the student experience during their studies.

Employers: Prior to the oversupply situation, employers would occasionally have vacant pre-registration posts due to the poor quality of applicants. With managed numbers, employers would want an assurance from HEE that the workforce forecasts are sound and also from universities that rigorous selection processes are being put in place to ensure students meet both the academic standards and display the professional values and behaviours required to provide care to patients. This would bring pharmacy in line with other healthcare professional programmes.

Universities: This may create financial pressures for universities. It would depend on how controls are determined, what the impact would be.

While the PhSC understands that this is a high-level consultation, there has been little information as to what these control mechanisms could include. Although this lack of detail is perhaps understandable given the complexity of the topic, it has severely restricted the debate. In essence, stakeholders are being asked to support in principle reforms where the ramifications cannot be known.

The PhSC suggests there is a need to consider how number allocations can eventually progress to take account of measures of the provision of high-quality MPharm education. Nevertheless, this will be a very complex measure to develop, refine and introduce. The response to question 4 further explores this issue.

Others:

HEE/NHS: This could assist HEE in meeting its remit of providing the right number of healthcare professionals educated to the correct standard. The NHS would be able to focus resources on training this appropriate sized workforce for the healthcare needs of the country.

The profession could benefit from ensuring that overall supply is actively managed to meet demand, and swings from 'surplus' to 'shortage' of pharmacists are avoided.

<u>Question 4</u>: Who should set the intake control limits, overall and for individual universities, and what criteria should they use?

The overall control limits should be set by HEE and HEFCE (similar to the HENSE approach used for medicine and dentistry) and reflect workforce requirements determined by LETBs. The challenge with this will be determining accurate workforce numbers as data from non NHS sources has not traditionally been accessed, but the recent CfWI report into pharmacy

represents a good start in gaining the national picture. Access to data on the MPharm through HESA needs to be improved to ensure MPharm students can be adequately identified – the PhSC and HEFCE will need to play a leading role in the coordination of this.

With regards to allocations to individual universities, whilst not supported by all, a majority of PhSC members indicated that they would welcome an initial transition period. To support the sustainability of schools, this may feature student numbers being allocated based on meeting a minimum number, with any surplus above this allocated in the light of intakes over the last few years. This will allow schools a period of time to adjust to the new environment. The number of student places should subsequently be allocated to schools of pharmacy based on the quality of the educational provision. However, there is also a view amongst some schools that a quality agenda should be implemented immediately if this option is adopted, as they think that a 'minimum number' could lead to confusion and delay of the inevitable quality allocation criteria.

We recognise that deciding on quality measures is a complicated process which will take careful consideration and discussion, therefore clarification on timelines surrounding the management of numbers will be essential.

Data on quality could come from several sources, but notably the professional regulator, and may include intake quality, registration rates, employment rates, attrition rates, investment levels, contributions to regional professional development and the quality of pharmacy-related research. The PhSC and its members must be properly consulted when devising this methodology. Furthermore, we would suggest that if a managed system were to be introduced, we would suggest that a moratorium should be placed on new schools of pharmacy.

Question 5: Should international students be included in the intake control?

No. International students should be factored in separately and above and beyond any capped numbers. The cost of all clinical placements should be funded directly by the student. Arrangements between universities and employers to take international students on placement should be explicit that these are above and beyond the cap and must not impact upon the ability to train home students. Numbers of international pharmacists entering the pharmacy workforce post qualification will be regulated by the need to meet the requirements for gaining a work permit and Tier 2 visas.

Creating a break-point during study which restricts the numbers of students going on to qualify as registered pharmacists

Question 6: What would be the impact of this approach upon patients, students, employers, universities and other stakeholders? Please address each in turn.

Students: The PhSC firmly believes that a dividing point in the undergraduate degree programme would set pharmacy aside from every other healthcare professional programme, and potentially make it much less attractive to students. This option would combine the disadvantages of both the other options, still requiring schools to be allocated student numbers, while preventing students who would have already made a large investment in becoming pharmacists (typically circa £37k in student loans alone at year 3) from completing their

education.

Implementation of this option is likely to detract from the attractiveness of the degree and generate dissatisfaction amongst students who may just fail to make the grade to proceed along the pharmacist route (leading to growth in complaints and academic appeals). There is also a moral issue of inviting students to accept large debts during their studies, only for many to be directed sideways and undertake something they did not want to do.

HEE/NHS Under the Modernising Pharmacy Career proposals for undergraduate education, the break-point option would not be possible, as one of the major proposals is to give students clinical experience from day one. Implementing this option would therefore be expensive and wasteful if the students do not then go on to become pharmacists.

Professional regulator: If significant numbers of students who have completed the first stage of an MPharm do not go onto to graduate as pharmacists, this part of the course would need to be made more generic. This would be needed to meet the requirements of all students by providing the essential skills necessary for general employment in a healthcare science arena.

The General Pharmaceutical Council, the professional regulator for pharmacy education, requires an integrated and spiral curriculum with students having to adhere to a specified code of conduct and meet fitness to practise requirements. Having a significant number of students who do not progress to become pharmacists would mean that it would be difficult to impose these professionally focused standards and fitness to practise requirements.

Patients: The model does not fit with the proposed developments in pharmacy education and an enhanced clinical focus aimed at improving patient care. In making the career progression less certain, it is likely to deter the most able applicants from applying.

Question 7: At what point in the current curriculum would it be possible to make such a break?

The PhSC is not in support of creating a break-point (see answer to question 6) but after year 3 would be the most feasible, so that an exit BSc award can be made, otherwise we would support the end of year 4 (degree award at present).

Question 8: Is a formal progression control mechanism (such as a test or exam) required, and if so, what form should this take?

The PhSC is not in support of creating a break-point (see answer to question 6). However, if it were to happen the answer would be yes, with a rigorous assessment of professionalism, skills and behaviours. A knowledge-based assessment in isolation will not select the best students to practise as pharmacists.

Overarching questions

Question 9: What contributions could curriculum reform make to managing of a sustainable supply of graduates?

Curriculum reform should contextualise learning at an earlier stage in the degree process thereby eliminating the need to reteach, particularly at the pre-registration year level. There needs to be more direct and sustained patient contact at an earlier stage. This will ensure that students are able to fully contextualise their learning, are well aware from an early stage what their future roles are likely to be and whether they are suited to them, as well as enabling them to make informed career choices.

Question 10: What approaches could be taken to accommodating international fee-paying students in each of the options above, which could be delivered by the available capacity to train within the NHS?

It is envisaged that those international students who wish to undertake their professional training in the UK, would need to fund their own pre-registration placements by paying a fee to the placement provider. It is understood that these placements should not encroach on those provided for UK/EU students and so would need to be demonstrably additional provision. Schools of pharmacy would need to develop progression routes that allowed tier 4 visas to be used and would, consequently, have to develop a form of integrated five-year programmes to achieve this, following a model similar to that of the University of Bradford's five-year degree programme.

Question 11: What impact will each of the options outlined above have on ensuring that local health inequalities and labour market conditions are addressed as well as the national picture?

Workforce planning needs to reflect local geographies as well as the total national figure. LETBs need to be actively engaged within this. There should be some consideration of the geographical distribution of schools of pharmacy to support this but this should not be to the detriment of quality.

The PhSC, however, believes that it will be necessary to have some form of 'national' level administration; otherwise there is a risk of inequity across a range of providers due to demand being locally driven.

It would be important to be mindful of the fact that MPC tying in pre-registration to the MPharm structure would impact on the mobility of students wherever they are studying. This, for example, would affect Scottish universities because there will be essentially no possibility for students to move from Scotland to England for pre-registration training or vice versa.

Question 12: How feasible is it to introduce any one or a combination of the options for 2015-16? What other timescales could we work towards?

It is already very late for 2015/16 recruitment (bearing in mind recruitment cycles and marketing requirements) and such requirements of universities should be considered to ensure the practical implementation of potential reform.

The PhSC endorse the recommendation by the CfWI report that any implementation should be carried out in a staged approach. This will help secure the student interest and also ensure the

financial sustainability of pharmacy schools so that they can provide high-quality education into the future. The biggest challenge will be producing a mechanism to manage numbers that is acceptable to stakeholders and not open to any legal challenge. Ideally, the overall numbers should be reviewed annually and a transitional period introduced.

Question 13: Which of the three proposed options, or what combination of them, would you prefer, and why?

The PhSC is broadly supportive of the move towards the management of student entry into the MPharm (Option 2). However this is not unanimous with some members seeing merits in Option 1. The Council remains concerned about the detail of how Option 2 may be achieved, particularly with regards to: timescales, numbers, and method of allocation and its support is conditional on how these concerns would be resolved. In a managed entry system, the Council would like a transitional period to assist schools moving to the new regime, with minimum numbers and some awareness of historic numbers initially, before progressing to allocations based on quality. The PhSC would want to be fully consulted when devising this methodology. The Council sees no merit in Option 3, the 'break-point'.

Question 14: Are there other options that could be implemented?

A range of other options were considered by the Royal Pharmaceutical Society in their recent 'thought paper' entitled *Options for Controlling Entry to the Pharmacy Profession*, but all were considered too high risk in terms of maintaining the quality of pharmacy services, and 'securing the student interest'. Some schools are suggesting that the delivery of MPharms, for example through managed mergers or other methods, are factors that may also need to be considered.

Question 15: Are there any other points relating to this consultation that you would like to raise?

High quality care and the needs of the future healthcare/patient population must be at the centre of all decision making. The Government has a long standing commitment to develop the contribution made by pharmacists to the healthcare system, for example through 'medicines optimisation' and promoting public health ('healthy living pharmacies'), and this could be compromised if the underpinning education is not given the necessary support. The focus of this consultation must, therefore, be to allow the education of the highest quality science-based healthcare professionals to deliver this agenda. To this end, the sector supporting pharmacy education needs to be sustainable to allow planning for the long term and so should be appropriately resourced.