



November 2013

# Ensuring a sustainable supply of pharmacy graduates

A response to the HEFCE consultation by the Pharmacists' Defence Association

| representing **your** interests |





# Contents

page

**Section 1** – Introduction ..... **03**

**Section 2** – Summary of the PDA position..... **05**

**Section 3** – Answers to consultation questions..... **07**

**Section 4** – Answers to overarching questions..... **14**



## About the Pharmacists' Defence Association (PDA)

The Pharmacists' Defence Association (PDA) is a not for profit defence association and trade union for pharmacists. Its aim is to support the needs of individual pharmacists by representing their interests and, when necessary, defending their reputation. The PDA is the only organisation that exclusively looks after the interests of employee and locum pharmacists across all sectors of pharmacy, and it currently has more than 22,000 individual pharmacist members.

### The PDA's primary aims are to:

- Support pharmacists in their practice, employment and legal needs
- Provide representation for its members
- Proactively seek to influence the professional, practice and employment agenda so that members can deliver high quality care
- Lead and support initiatives designed to improve the knowledge and skills of pharmacists towards improved risk management, safer practice and high quality patient care
- Work with like-minded organisations to deliver these aims
- Provide insurance cover to safeguard and defend the reputation of the individual pharmacist.

The activities of the PDA lead it to experience a large number of critical conflict incidents where it is required to provide support to PDA members. This largely occurs in the areas of employment conflicts, professional regulatory incidents, civil claims for compensation and criminal proceedings against pharmacists. This provides the PDA with a rich and unique vein of up to date experience that informs its policies. The proposals put in this submission are largely built upon this experience.

The PDA believes that this consultation is to be welcomed but that it is well overdue. It makes this response on behalf of its members – practising pharmacists, pharmacy graduates and undergraduates who will be and who already are affected by this issue in their daily employment and in the development of their future careers.

The PDA has been concerned about the oversupply of pharmacists for some time and addressed the subject in a series of member conferences held throughout the UK in the spring and summer of 2012. A summary of the outcome of these events was published in the autumn of 2012 (Insight magazine).

It was very apparent, that if the profession was to resolve the problem of a potential oversupply of pharmacists, it first needed to establish a workforce plan which would inform thinking around the numbers of pharmacists that were actually needed.

Through the conferences, plenary, and focus group sessions as well as general concerns expressed by many PDA members through advice line activity, it was clear that a significant part of the problem is that the profession has failed to agree a common narrative about an overall direction for pharmacy and consequently for pharmacy roles and careers.

A new narrative regarding the direction of pharmacy needed to be created, this needed to be built upon not only the hopes and aspirations of pharmacists, but had to be overlaid onto the current challenges facing the NHS, the views of other healthcare professionals and the views of the public.

Work undertaken in that regard identified seven policy principles;

- Delivering patient safety had to be at the core of any considerations about pharmacist roles.
- Community pharmacists had to be more accessible to the general public not less so, and this must be supported by appropriate regulation on supervision.
- The commoditisation of pharmacy services (as exemplified by MURs) had to be halted and the professional autonomy of the practicing pharmacist had to be enabled.
- New roles needed to be developed for pharmacists in the community – but not at the expense of delivering a safe community pharmacy supply function.
- New roles needed to major on the unique skills of pharmacists.
- New roles needed to increase the availability of pharmacists to patients in the community/ primary care setting – the importance of the pharmacists involvement in Public Health needed to be majored upon.
- Working from these principles it became possible to develop a workforce plan.

Since the autumn of 2012 a number of developments have occurred which make the creation of a workforce plan much more viable.

1. The Scottish Government policy document entitled 'Prescription for Excellence' was published in September 2013
2. The PDA's Scottish Road Map policy, "Review of NHS Pharmaceutical Care of patients in the community in Scotland" was submitted to the Scottish government review in July 2012 and the PDA's English Road Map policy "Reducing unnecessary A&E attendances and avoidable hospital admissions in England" was published in October 2013.
3. The Royal Pharmaceutical Society Now or Never policy was published in November 2013.

These three independent policy papers provide the seminal basis upon which a strong and exciting narrative for pharmacy role development can now be created. A narrative around which practicing pharmacists can unite and as a result of which highly beneficial services for the public can be developed.

Sadly however, there appears to be no solid narrative from NHS England on the future role of pharmacists, other than the continuation of the supply plus approach to community pharmacy (delivery of MUR style services). Unless NHS England makes its position on pharmacy and pharmacists clearer it will be impossible to balance the supply and demand of pharmacists and problems will continue. It will not be possible to establish even broadly, the right number of pharmacists that will be required and therefore the impact of dramatically reducing the numbers of pharmacists being produced by Schools of Pharmacy will be unpredictable.

Notwithstanding the above, as things currently stand, there is patently an oversupply and continuing this oversupply will be highly damaging. Unless it is curtailed the profession will be devalued; students will be failed; patients will be put at risk and problems with pharmacist employment would come to blight the profession.

## Summary of the PDA position on the options identified

The PDA believes that intake control is necessary and that this must be linked to a government workforce requirement plan as is the case for other healthcare professions. The PDA argues that the transfer of Pharmacy Education from general science to health funding is long overdue and should be facilitated as quickly as possible. This will further enable the development of a centralised pharmacy planning function, a better geographical distribution of schools of pharmacy (and thereby pharmacists) and would provide a foundation upon which local academic deaneries could oversee placement training.

Three options were identified in this consultation

### 1. Allowing the market to determine outcomes

Market forces work best where there is a simple relationship between the demand and supply sides; where the supply can respond quickly to changes in demand; and where demand and supply are broadly distributed. The “market” in pharmacy graduates is none of these. There are many stakeholders who have an interest in the number and quality of pharmacy graduates and they place necessary constraints on the way that the market operates. It takes a minimum of seven years for a student to gain the necessary A levels and higher education to enter the profession and any change in demand cannot be accommodated in much less than a decade. Although there appear to be a large number of employers (demand side) in practice there are a very few who employ the majority of graduates; they operate in a highly regulated pharmacy market, face the same challenges and pressures; and work closely together in a number of pharmacy forums. The demand side is well organised and not broadly distributed.

It is the very reliance on market forces in a market that cannot operate in a “free market” manner that has resulted in the current over-supply problem; relying on the market to fix the problem is unrealistic and would be misguided.

In the United States, where there is an almost identical oversupply problem, intake controls are being advocated because relying on the free market will delay remedial action and result in drastic impact on educational institutions<sup>1</sup>.

In the UK at the input level, market forces have resulted in a doubling of the numbers of students entering a pharmacy degree course. This is a function of the growth in the number of pharmacy schools combined with the increase in places at existing schools, where a removal of controls on the numbers of students with the best A level grades has resulted in pressure to open up the MPharm to more students. Pharmacy has proved to be an attractive course for high quality applicants who are seeking a “safe” vocational degree.

At the same time employers have seen an increase in the number of pharmacists on the register and can now fill the majority of their vacancies from the current stock of pharmacists. They no longer see the need to train a large number of graduates with the result that the largest companies have more than halved the number of training places available. Furthermore they are forcing reductions in salaries and imposing working conditions that increase risk.

Even if it is assumed that market forces will eventually balance the number of entrants in to the degree with the number of jobs for them that will take in excess of 10 years. During that time initial research undertaken by the government (through the Centre for Workforce Intelligence) indicates that nearly 7,000 graduates will never actually achieve registration with the GPhC as pharmacists due to the unavailability of training places – and even that calculation assumes that the number of training places stays relatively static. Using figures generated by Modernising Pharmacy Careers workstream 1, this is likely to be at a cost to the taxpayer of in excess of £600m<sup>ii</sup>.

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

We believe that this is the only feasible option albeit predicated on an assumption that we have a workforce plan that tells us how many pharmacists we need and therefore how many student entries to degree courses would be needed to deliver that number of pharmacists. In the absence of that knowledge, all that can be achieved would be a reduction in the numbers produced in the hope that the current oversupply can be reversed.

Ultimately, matching input to output (through a credible workforce plan) will result in attracting the highest quality students as it will be possible to (almost) guarantee that they will find suitable employment upon qualification. Employers will benefit from the highest quality employees and patients should receive the best quality care.

Applying input controls to each school could also be used to facilitate a better geographical distribution of pharmacists and allow the quality of education to be better managed.

A new improved system would also need to ensure that there were enough high quality pre-reg training placements available to support the input/output controls. This would require a more proactive and central approach to be taken in this respect also.

However graduates will expect rewarding careers with the potential for career development and specialisation. Unless the NHS has a plan for pharmacy it will find it difficult to apply proper input controls and it will fail to make the most of the pharmacists that are produced.

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

To take considerably more students than could qualify as an MPharm would be iniquitous and dishonest, as a significant proportion would end up with a qualification other than that which they believed they were studying for.

The ultimate effect would be to make pharmacy a post graduate/second degree choice. Although this strategy may restrict the numbers going on to register as pharmacists it would require giving those who don't make the grade some other meaningful qualification which would necessitate a major course redesign.

The PDA fundamentally disagrees with this approach.



## Allowing the market to determine outcomes

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

This would be fundamentally unsound and would result in a poor outcome for all stakeholders. Some short term benefits for employers would be wiped out by medium to long term disadvantages; all other stakeholders would experience major issues in a relatively short time frame.

### Patients

**Patients will not benefit from potential new services; they will experience poorer current services; and they will experience increased risk.**

Considerable evidence already exists to show that in an oversupply of pharmacist situation, many community pharmacy employers do not utilise the oversupply to increase the availability of pharmacists to patients or to provide improved patient services. Instead they drive down pharmacist salaries and impose more onerous working conditions, confident in their ability to replace any pharmacist prepared to defend quality of services.

The experiences of the PDA in defending pharmacists demonstrate that the trend will be;

- Community based pharmacists will be working longer hours under greater pressure.
- Employment pressures will lead to even greater adherence to SOP's and a significant dilution of professionalism.
- There will be a strong disincentive for community based pharmacists to speak out against poor standards of questionable working practices for fear of being replaced. This will undermine the benefits to patients of strong professionalism.
- There will be less transfer of clinical skills from hospital pharmacy to the community as the difference in salary levels and general employment conditions means that hospital pharmacists will find little incentive to work in the community sector.

The net result will be patients receiving less support in taking their medicines safely and achieving better outcomes from their medication regimes. There will also be a greater risk of side effects, unintentional consequences of taking medicines and medication errors.

### Students

**It is on students that the most brutal effects of relying on the Market will be felt.**

Students who choose to enter an MPharm degree programme do so because they believe that they will have rewarding careers and that they will be likely to be able to find employment at the end of their education and post graduate training. They have a lower risk threshold than many other students – and that is a trait that is valued in pharmacy – a profession that is relied upon to minimise risk.

Applicants of the highest calibre will generally seek courses that will guarantee employment; as such pharmacy will come to attract applicants of a lower calibre.

Ultimately, students will stop applying for the MPharm degree when it becomes known that there is a real chance that they will be unable to find training places; maybe unable to register as a pharmacist; and have a much lower expectation of employment at a level of remuneration that reflects their skills and knowledge. We believe that it will be at least another two years before current problems in finding training places and employment will result in any decrease in applications to schools of pharmacy. Given that the number of applicants currently far exceeds the number of places available we believe that it will be at least a further three years before there is a decrease in the number of students entering the MPharm course. Since students entering the course this year will not qualify for another five years this means that it will be a full decade at best before the market forces start to reduce the oversupply of pharmacy graduates.

Against the backdrop of student oversupply, there will be intense competition for training places with the result that graduates will take places without remuneration. Some employers are already keeping the £19,000 training subsidy payments made by the NHS to train Pre-reg's and are instead using them to boost their profits. As graduate numbers rise and training places further reduce, this practice will inevitably become widespread. It will be graduates that can rely on parental support who secure training places rather than the best quality candidates and this will further fuel inequality.

We accept that some students may have the opportunity to change direction through the life of their course but this is limited and unlikely to have any significant effect on the number of MPharm graduates. Furthermore the MPharm degree is designed to produce pharmacists and graduates do not have a significant number of alternative career paths to pursue.

Conservative estimates of the number of students who will not have been able to complete their registration by the end of the decade exceed 6,800. This is a scandalous waste of potential at an enormous personal cost for each and every one of those students – each one finding themselves unable to pursue their chosen career and left with no obvious alternative. This is also an unacceptable waste of public funds.

## Employers

**In the short term employers will benefit from the oversupply of pharmacy graduates by cutting costs through reducing their expenditure on training and driving down pharmacist salaries, of this there is already considerable evidence available.**

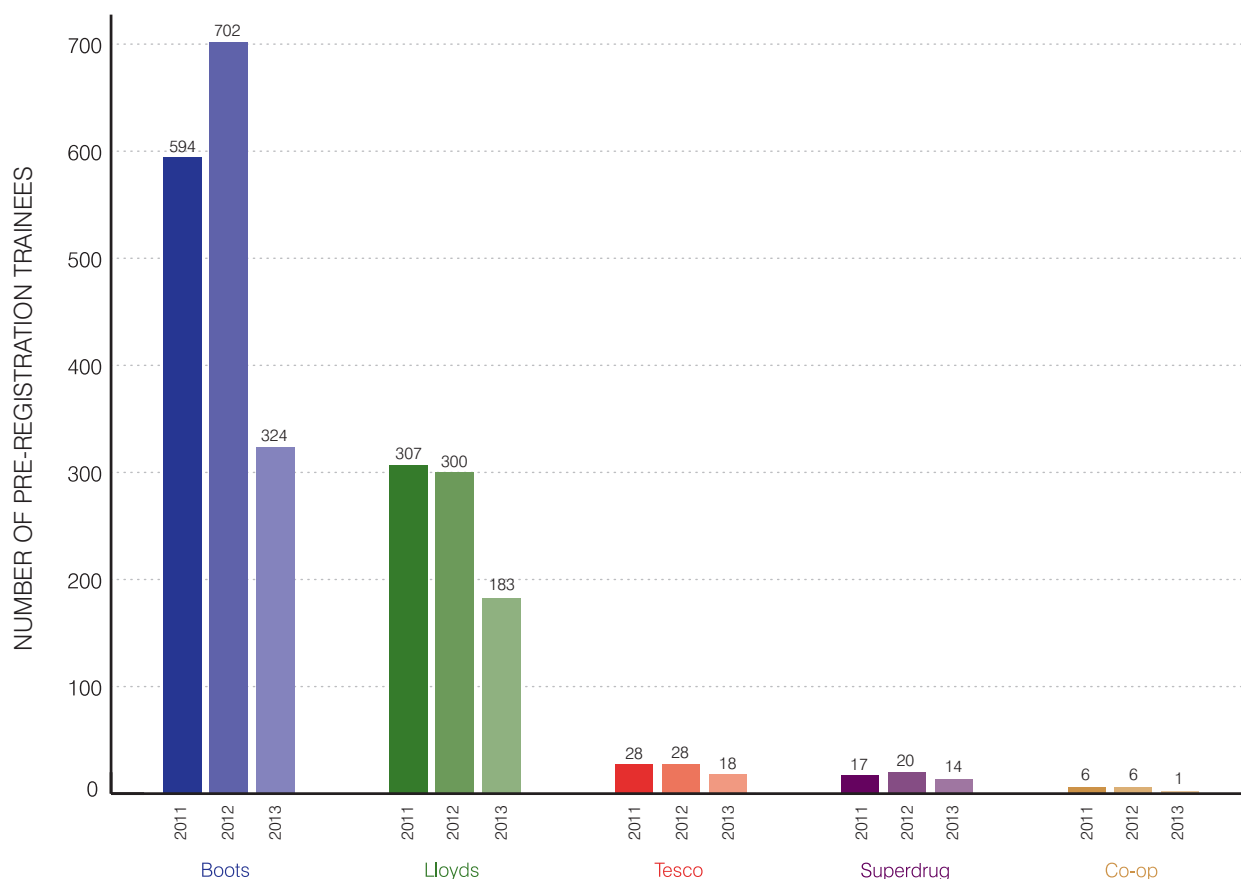
The vast majority of pre-registration training is currently provided in the community sector and therefore any trends occurring there are likely to have a magnified effect.

The Cost of Service enquiry in community pharmacy carried out in 2010<sup>iii</sup> showed that large multiple pharmacy chains (LMPCs) had the largest cost base, partly driven by higher head office costs. Since the remuneration set in

the community pharmacy funding framework is a weighted average of costs the LMPCs are operating at a cost disadvantage compared with other contractors and will always be seeking ways to reduce their costs and make their pharmacy operations more profitable.

Part of the head office cost is made up of the pre-registration training and tutor support programme. At times of pharmacist shortages, the turnover of managers working for the multiples is always higher. In such a situation, heavy involvement in the pre-reg training programme results in the recruitment of large numbers of managers and produces managers accustomed to their working practices. Consequently, the large multiples are involved in some very large scale pre-reg training programmes. However since there is now a surplus of pharmacists, the turnover of incumbent managers is reduced and the number of pharmacists looking for managerial posts has increased, consequently, many LMPCs are no longer investing in training and have more than halved the number of training places available. This reduces their head office cost base and increases their profitability.

Information provided by the GPhC via a Freedom of Information access inquiry is shown in the table below.



There is also evidence that LMPCs are forcing down pharmacist salaries; in areas where there is an oversupply of pharmacists they are reducing locum rates by up to 30% and some LMPC's have also stopped paying any travelling expenses. This opportunism significantly devalues the profession making it even less attractive to high calibre future applicants.

We understand that this makes sense for employers in the short term but it is not good for patients or the profession. Pharmacist salaries make up 20% to 25% of the cost of running a pharmacy; any reduction will find its way through to the contract funding framework thus further reducing remuneration and viability.

Lower rates of participation in training by LMPCs will lead to an overall reduction in the availability of centralised training given to graduates. This will rapidly exacerbate the over-supply problems in so far as it will generate an even greater number of graduates who will never qualify as pharmacists than has already been predicted.

## Universities

We know that academic pharmacists are already concerned about pharmacy student numbers – not only because of the excess of students applying for training places but also because their capacity to provide the quality of education necessary is at risk due to the worsening shortage of lecturers and tutors. Many of the academics who led the increase in the number of pharmacy schools are due to retire and there are too few academic pharmacists to replace them and provide adequate academic leadership.

We are also aware that some schools of pharmacy are under pressure from vice chancellors to take more students as they attract high levels of funding. If the numbers continue to rise the quality of education will fall, more students will find it difficult to find pre-registration training places and more will fail the GPhC requirements for entry to the register.

## Other Stakeholders

As the major representative of employee and locum pharmacists the PDA can expect to see a rise in;

- disputes between employers and employees
- referrals to the regulator
- more medical negligence claims due to the impact of increased workplace pressure

All of these mean risk to patients and damage to the profession.

The PDA want to see high quality graduates entering a rewarding and well remunerated profession where pharmacists make interventions with patients that improve the quality of their healthcare and have beneficial impact on their lives. Promulgating the current situation will fail to deliver this vision. Market forces should not be allowed to balance the demand for and supply of pharmacists.

### ***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?***

Prospective pharmacy students need better information on their prospects of being able to obtain training places, what track record these training places have in terms of exam results and being able to enter onto the register and also on what their subsequent prospects are in obtaining employment.

Some schools of pharmacy, in a bid to attract the best applicants are currently telling A level students that they guarantee 100% employment after leaving their pharmacy school. This rather disingenuous approach fails to make clear that they merely refer to the pre-registration training year and not to the prospects of securing gainful employment thereafter.

If the current trends continue as many as 17% of pharmacy graduates may find themselves unable to follow their chosen career path. Many would find such a wastage rate both surprising and unattractive.

They also need to know how their particular university performs in terms of being able to facilitate training places and provide education of sufficient quality to gain entry to the register.

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

Introducing intake control is the mechanism that will have the quickest impact and that offers the best opportunity to control quality and the balance supply and demand of pharmacists.

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

### Patients

Balancing the number of applicants to universities with the projected demand for pharmacists provides the best basis for providing high quality pharmacy services. Pharmacists who are more secure in their employment positions are more likely to be able to resist inappropriate commercial and organisational demands and put the interests of the patient first. Pharmacists employed under reasonable contracts and adequate working conditions are likely to be under less stress and less likely to make mistakes which put patients at risk.

Quality can also be maintained and improved by levelling up standards of education at schools of pharmacy through input restrictions. We also believe that a better balance between supply and demand can result in more rapid development of new pharmacy services to the benefit of patients.

We contend that restricting input gives the best opportunity to protect patients and provide better quality of care.

### Students

Students seeking to enter an MPharm programme are looking for a rewarding pharmacy career – they are entering a vocational pharmacy programme not a general science degree course. As such they are more risk averse than many of their contemporaries – a trait that the profession values.

Although input controls will make it more difficult for applicants to gain entry to an MPharm course, students will benefit from greater security at the end of their degree – they are more likely to be able to obtain a training place and ultimately employment.

### Employers

Employers would need to provide more training places to ensure an adequate supply of good quality pharmacists. To do this they would have to maintain their investment in their central training and development functions; they would also have to provide adequate remuneration and better working conditions.

Although this would appear to be a disadvantage to them as it would prevent them cutting their cost base they would benefit in other ways. Costs will be reflected in the NHS remuneration through the community pharmacy funding framework; pharmacist quality will improve and new opportunities to provide pharmacy services will be offered.

Perhaps the greatest benefit to employers, however, is the enabling of better long term planning. If they have greater certainty about the number of pharmacists that they need, the number that they can expect to enter the register and the number they need to train, the easier it will be to ensure that they have the right resources in place. It is scaling up and down that costs money and time and reducing uncertainty will be beneficial.

### Universities

Overall the number of pharmacy student places will fall with some universities experiencing a greater reduction in places than others, some may need to close their pharmacy courses altogether. This will result in a reduction in funding to a greater or lesser extent.

However we are concerned that the universities will be unable to continue to offer education to the same standard as they do now if controls are not established.

Applying input controls will give greater certainty about future numbers and allow proper planning of academic staff levels and expertise. Furthermore it will ensure that applicants are of the highest standard.

In the United States academics are advocating halting the expansion in schools of pharmacy and reducing numbers of students in existing schools. They want to see more attention paid to quality of education and establishing new roles for pharmacists.

### Other Stakeholders

The PDA does not wish to see a situation where pharmacists are subject to undue pressures and are operating in an unsafe environment. Applying input controls would result in:-

- fewer disputes between employers and employees
- fewer referrals to the regulator
- fewer medication errors
- improved patient experiences

Better educated pharmacists with the confidence to insist on maintenance of professional standards over adoption of overtly commercial and organisational requirements is in the public interest.

#### **Question 4: Who should set the intake control limits, overall and for individual universities, and what criteria should they use?**

This should follow a similar pattern as seen for the medical and nursing professions. Overall input levels should be set by the Department of Health with reference to the NHS and employer/ employee representatives. This should be determined by the Pharmacy Workforce Plan. The allocation of places across universities should be set by HEFCE in collaboration/ consultation with the Schools of Pharmacy.

Overall the number of students must be appropriate to ensure a supply of pharmacists adequate to meet the demand taking in to account existing and new roles. At a university level the geographical distribution of pharmacists must be taken in to consideration but the overriding consideration must be the quality of education.

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

There is a strong attraction of the MPharm to international students and a benefit to universities and to the UK economy in attracting them. Overall attracting international students is good for the economy, good for standards and good for the universities.

However the response to this question depends on how pre-registration training places are enabled, allocated and supervised.

If there are no controls on training places and taking on an international student would not deny a training place to a UK student then the number of international students should not be controlled as such. However, what should

then be considered is whether the number of students being trained by a Pharmacy School would still allow the school to maintain quality standards of education.

If training places are limited then the number of international students must be taken in to account in overall student numbers and limits imposed that ensure all UK students who require them have training places available to them.

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

To a small degree this already happens; universities divert students who are unlikely to complete the MPharm programme, giving them instead the opportunity to gain a bachelor degree in a related science subject. However this is uncommon and it is not an approach that is easily extended.

The PDA fundamentally disagrees with this approach, as a large scale solution to the current oversupply situation.

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

### Patients

Quantitatively, applying a break point would have very similar effects on patients as applying input controls. Since the ultimate expression is in the control of graduates and hence the production of pharmacists the outcome is very similar to this group. Qualitatively, however, such an approach could result in less time for professionalism to be embedded into the undergraduate course resulting in a poorer grasp of professional ethics and this could ultimately be of detriment to patients. The medical profession inculcates its undergraduates as a professional from day one of the training period and this has been highly beneficial to patients; pharmacy must follow suit.

### Students

This is a difficult option for students. It would mean that a significant proportion of students would not go on to achieve the MPharm degree and would not enter the profession for which they applied to study and have been working towards. Any student failing to move through to the end of the MPharm would be faced with re-thinking their career choices.

An alternative degree endpoint would be required that recognised the achievement of those students failing to pass through the breakpoint to complete the MPharm. Students receiving this qualification – whatever it might be – would then find themselves competing in the jobs markets with other science graduates, perhaps with better targeted and more relevant qualifications.

The uncertainty that would be a constant factor for students up to the point of knowing whether they would progress to the MPharm would be a source of stress and could result in impaired performance.

This option could only be pursued once students already in the system have worked through; applying a break point in the next five years could result in a large proportion of those already in the system failing to make it through the MPharm programme. These students would then find themselves in the jobs market without any properly designed qualification facing competition for positions for which they have no real aptitude or desire. It is likely that if a break point were introduced for those already in the current five year programme, then this would lead to potential conflict and even litigation between students / their families and the universities.

### Employers

From the employers perspective this option is similar to applying intake controls. The result is that the number of pre-registration graduates will fall, the surplus of pharmacists will decline and they will have to begin to provide more training places again. However, the impact of the break point could provide employers with graduates that are less well prepared for healthcare roles and this would be disadvantageous.

### Universities

This is the most difficult option to manage for the universities.

Over the last few years the universities have re-designed their courses to bring forward professional law and ethics earlier in the programme, making it clearer to students from the outset what it means to be a pharmacist in terms of their duty towards patients and their need to maintain the highest standards of professional behaviour. From the outset students are inculcated in to the ethos of professional practice and their expectation of working in that environment are reinforced. They understand that failing to behave in a way consistent with professional standards will have consequences on their ability to register. Additionally, the student fitness to practice programme although new, is moderately well developed with numerous students already involved in fitness to practice conduct hearings at their local schools. Should a break point be introduced then this programme would need to be significantly reviewed.

Additionally, in order to create a break point which allowed an alternative career path the focus on professionalism

would have to be shifted towards the latter part of the MPharm course requiring substantial redesign of the programme. Furthermore, in order to create a meaningful qualification for students failing to progress past the break point, the universities would need to create a curriculum that delivered a good broad based science qualification with less emphasis on the clinical aspects of pharmacy. This adds further weight of content and complexity in to the post-break period of training making this period more difficult to teach and more intensive to study.

These factors are likely to reduce the overall attractiveness of the pharmacy course and lead to a reduction in the quality of the graduates applying.

The issue of managing student expectations would also add to the burden on universities. Since the number who would pass through the break-point would not be clear at the outset of a student's degree universities would have to invest more time and effort in to general communication with the entire pharmacy student body but more importantly in to providing greater feedback and advice to individual students.

### Other Stakeholders

The PDA already invests in the undergraduate programme through providing representation during student fitness to practice episodes as well as supporting law and ethics undergraduate curriculum programmes through risk management case studies. Such valuable support would be difficult to deliver if there were uncertainties about the extent to which such content was relevant to the student population.

The PDA also supports pre-registration graduates by providing significant levels of training and employment support. Creating a break-point would result in students arriving at the point of commencing their pre-registration training less well prepared in their clinical, legal, ethical and professional skills and knowledge.

The PDA would also be concerned on the impact that a break point would have upon the proposed incorporation of the training year as a split element in to the MPharm programme – a development that the PDA supports.

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

The PDA does not support such a break point proposal.

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

The PDA does not support such a break point proposal.

## Overarching questions

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

On its own curriculum reform will make no meaningful difference to the sustainable supply of graduates.

However the PDA favours the incorporation of the training year in to the MPharm curriculum and would welcome this development as part of the redesign of pharmacy student education. The training year incorporation is likely to impact significantly upon the quality and to a lesser amount, the quantity of pharmacy graduates.

### **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?**

The PDA recognises the value that overseas students represent to universities both in terms of the cultural diversity that they introduce and the financial contribution that they make. There is no reason to limit the number of foreign fee-paying students unless they prevent a UK student accessing a pre-registration training place.

If sufficient training places can be made available there is no reason why international students should not progress to full UK registration with some charge being made by the NHS for the pre-registration year.

### **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?**

The free market and break point options will have no impact on local health inequalities as they will still allow schools of pharmacy to operate in areas where there is a demand from students.

Controlling intake numbers could make a difference in local health inequalities only as part of an overall workforce plan and this does not appear to be explicit in any of the options. The development of a workforce plan would not only need to match supply with planned demand, but it should also have a geographical element to it. A geographical element in a controlled plan would put schools pharmacy in areas where there are shortages of pharmacists and this

would help to address health inequalities. Additionally, a geographical control would also ensure that the schools of pharmacy could support a post graduate deanery structure going forward.

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

Relying on market forces is the status quo and is the default position; this will happen unless action is taken to stop it.

The PDA believes that it would be iniquitous for any student to be taken on to an MPharm programme to find that controls had been imposed during their period of study. Assuming that a break-point could be introduced in 2015-16 this could only be effective for students entering the MPharm programme in that year; the earliest that this then could be effective would be 2020. Wholesale redesign of the curriculum required by creating a break-point is not feasible for 2015-2016 or indeed within the next four years.

Introducing intake controls for 2015-16 is perfectly feasible albeit with some difficult decisions being required and perhaps (in the absence of a current workforce plan) an imperfect method of allocating places between universities being utilised. The development of a workforce plan is vital and this work should be undertaken urgently. Prolonging any decisions that need to be made will simply make the situation worse.

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

PDA supports limiting intake as this provides the only realistic course of action for controlling numbers in a reasonable time-scale. This option gives the best outcome with the lowest impact on each stakeholder group whilst maintaining future flexibility. Such an option should be deployed in combination with a consideration of the optimal geographical spread of pharmacy schools.

This last point (linked to a post graduate deanery) is also important because it enables a broader review of pharmacy post graduate education needs to be undertaken.



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

The issue of free market forces being involved in the creation of pre-registration training posts has now become a problem and the PDA believes that pre-registration training posts should be taken under the control of the NHS. Community pharmacy contractors should provide pre-registration training on a quota basis conditional upon the number of pharmacies that it operates and the number of NHS contracts that it enjoys. This would protect the integrity of the training places which under current arrangements are being removed simply through commercial considerations. A new approach which guarantees the quantity and consistency of training places through service level agreements would lend itself more to a controlled approach to training provision.

Additionally, such an approach would ensure that if controls were applied at the input stage so as to match the predicted demand (determined in a pharmacy workforce plan), then the requisite number of pre-reg training places could also be guaranteed.

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

We believe that a much wider consideration of pharmacy education is required including:-

1. New roles for pharmacists involve much more prescribing and direct clinical relationships with patients. As such, the PDA believes that some pre-registration training should be provided in the primary care pharmacy setting. This will also help to secure a higher number of training placements when coupled with that already provided in community and hospital pharmacy.
2. The General Pharmaceutical Council must do more to raise standards at Schools of Pharmacy through its pharmacy school accreditation process. The NHS, the government and the profession demand that pharmacy is a healthcare profession. In some pharmacy schools however it is still the case that the university believes pharmacy to be primarily a science based subject and not a healthcare one. This perception must be addressed.
3. Schools of Pharmacy must demonstrate how they are dealing with the diversity and equality issue; these are key challenges for society in general that need attention. Applicants from both poorer backgrounds and also those from ethnic minorities should receive equal treatment from Schools of Pharmacy during the application process and beyond.
4. The correlation between Pharmacy Schools and pre-registration exam results needs to be carefully examined and acted upon.
5. Workforce planning at a national and local level is fundamental to this framework and is long overdue for pharmacy.
6. Incorporating the pre-registration year in to an extended 5 year MPharm.
7. Establishing deaneries to find, supervise and control the quality of training places.
8. While in pre-registration training placements students should receive NHS bursaries.
9. The obligation to provide work experience placements (not just full pre-registration training) should be built in to the community pharmacy funding framework as a condition.
10. There appears to be no solid narrative from NHS England on the future role of pharmacists, other than the continuation of the supply plus approach to community pharmacy (delivery of MUR style services). Unless NHS England makes its position on pharmacy and pharmacists clearer, ideally through the creation of a vibrant narrative and future role for pharmacists (as Scotland has done) then it will be impossible to balance the supply and demand of pharmacists and problems will continue.

- i. American Journal of Pharmaceutical Education; 77 (5) Article 90.
- ii. It costs £90,000 to train each pharmacy student – from Modernising Pharmacy Careers Programme; Review of pharmacist undergraduate education and pre-registration training and proposals for reform.
- iii. Cost of Service Inquiry for Community Pharmacy; Price Waterhouse Coopers;  
<http://www.pwc.co.uk/government-public-sector/publications/cost-of-service-inquiry-for-community-pharmacy.jhtml>



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