

Consultation Responses
Workforce Education Policy Team
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Dear Workforce Education Policy Team

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain. The RPS leads and supports the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

The RPS is ideally placed to play a valuable role in supporting the development of the pharmacy healthcare workforce. The RPS is the guardian of professional quality and standards and the promoter of excellent patient care across the profession. As the professional body we have links across the pharmacy profession and we represent all sectors of the pharmacy workforce as well as experts and partnership groups vital to the education and development of the pharmacy workforce. We are able to work across professions and specialities, contribute to discussions with Royal Colleges and we work to strongly support the multiprofessional approach advocated for by MEE. Please note that as the professional leadership body for the pharmacy profession, we are formally represented on the MEE Board.

Chapter 2

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

We welcome the proposals to create greater integration of workforce planning activity. This is a key mission for the RPS and we believe this will enable greater impact of the pharmacy workforce in providing pharmaceutical health care and medicines expertise. In addition to the objectives outlined in the consultation, we would welcome investment in education and training and subsequent investment in patient safety and improving healthcare outcomes; a multiprofessional approach to the development of the healthcare workforce; and an increased focus on clinical and professional leadership. The NHS is an important employer of pharmacists however it is important to remember that many members of the profession are not directly employed by the NHS and many are employed in roles not directly involved in delivering patient services e.g. pharmacists in industry, research, academia etc.

Through its formal representation the RPS is aligned with the views of MEE as follows:

- In order for the NHS to be recognised as a world class employer; education and training must aspire to excellence: competence is not enough. We need models to support pharmacists in their development at all stages of their career across all sectors of pharmacy.
- There is a need for increased clarity and transparency on funding for education and training, and how it is allocated and used. The RPS supports other groups and agencies in a call for a clear link to be made between funding and quality to duly reward and promote excellence, and that there are appropriate incentives to improve education and training where it is poor.
- The RPS welcomes a multiprofessional approach to the development of the workforce of the future whilst at the same time recognising the needs of the individual healthcare professions to develop excellence in their own areas
- The RPS would encourage a focus on the changing nature of the service, for example in the increasingly community-based settings for care and the patient journey. The planning of the workforce must be aligned with service development and financial planning. The new education and training system needs to be able to respond to the rapid pace of change within the service, providing high quality patient care outcomes in the settings of the future.

We call for national oversight of a set of integrated structural objectives for healthcare professions regarding these proposals. There should also be further clarity for how these proposals will be implemented for each individual profession. We request engagement with this and believe that as the professional body we could be the steward of pharmacy related structural education and training objectives for pharmacy including other pharmaceutical science programmes.

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

We believe that the opportunity for greater transparency around funding and a clear link between funding and quality of care, as well as the proposal in the consultation document for a new national organisation providing oversight and the ability to bring together the professions and the service, will all contribute to ensuring the necessary focus to deliver the required changes and improvements in the overall system.

For the smaller professions, such as pharmacy, it is important that there should be a greater degree of national planning and oversight. National accreditation and standards will need to be in place to ensure that the pharmacy workforce can move between geographical areas whilst still maintaining delivery of services. We also believe that it will be important to forge closer links between healthcare providers and academia and the proposals need to support this process. In order for the proposals to succeed it is important that providers understand the education supply chain and what HEIs are able to provide. An integrated process is required to support the proposed changes and education, including recognition of the education needs of non-patient facing pharmacy roles, needs to be a fundamental part of this.

Chapter 3

3.2 Our profession also includes pharmacists working in non-patient facing roles e.g. in science, research, primary care and academia; as well pharmacists working as locums, relief pharmacists and a wide range of other roles including regulation, clinical trials and industry. It is vital that all members of the pharmacy workforce are considered when developing these proposals further.

The table summarising the healthcare workforce in paragraph 3.2 (page 20) under-represents the NHS-contributing pharmacy workforce considerably (15,000 is quoted), possibly by using data exclusively from the NHS Information Centre workforce census 2009 which did not include pharmacists working within contracted community-based services. There are around

49,000 registered pharmacists in Great Britain of which around 70% work in community pharmacy and around 20% work in hospital settings. The RPS is now uniquely placed to contribute to comprehensive and more contemporary workforce data for the CfWI.

3.5 The consultation mentions community pharmacy teams however it is unclear how many aspects of the proposals will impact on the community pharmacy workforce (including pharmacists, pharmacy technicians and pharmacy support staff). Greater clarity is needed on this area and it is vital that these teams are considered as the proposals are developed further.

In pharmacy considerable progress has been made with skill mix and ensuring support staff are appropriately trained for their role is essential for safe and effective healthcare delivery. Clarification is required as to whether NVQ training would be included in the new proposals.

3.6 We agree that developing the workforce is the responsibility of everyone who supports healthcare delivery and welcome the role for national professional bodies including the RPS.

3.7 We agree that training and development of the wider healthcare workforce is important and believe that the needs of pharmacy support staff should also be considered.

3.15 We welcome the role for the professions in leading at a local and national level and agree that the clinical leadership of the pharmacy profession, led by the professional body, will help to raise standards.

3.19 We agree that there is a need for change and welcome the opportunity for multiprofessional workforce planning and development including pharmacy.

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

There are already a range of existing arrangements in place across the pharmacy profession. In particular pharmacists working for community multiple pharmacy chains and for the NHS already have access to training and education. Pharmacy organisations, buying groups, private companies, pharmacy media and wholesalers are also important providers of training materials within pharmacy. Clinical and specialist groups also provide education and training for pharmacists. It is important that existing provision of education and development within the profession is not lost, however there is an opportunity to ensure that pharmacists in all sectors are able to consistently access quality training and education regardless of their sector or place of work. It is important that this is not lost if training and development become market driven and that smaller providers are still able to access training and education for their workforce. Overseas students, and their associated funding streams, are vital to the viability of higher education and it is important that the new system does not constrain this in any way. We would welcome consideration of the training of pharmacists to work outside the NHS, for example in industry, clinical trials companies, MHRA, academia etc

The current contribution of HEIs to the healthcare system should be recognised and should be built on. HEIs educate students to produce a skilled healthcare workforce and this role is underpinned by research including practice research which supports innovation and best practice. HEIs also provide personal and professional development to the current workforce via postgraduate education etc. Existing relationships between HEIs and Trusts, the third sector and voluntary groups are valuable and should not be lost as a result of the proposed reforms. The impact of the proposals on the GB wide pharmacy student body also need to be considered.

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

We believe the key opportunities are to develop multiprofessional workforce development and reduce silo provision to professions. We believe this will improve interprofessional working and communication and improve outcomes through integrated patient care. It is important that, with the any willing provider model, all professions have an equal opportunity to access training which is of a similar quality and content. The multiprofessional approach should

include public health and social care as integration of these disciplines is crucial to improving health outcomes.

Chapter 4

The new framework for planning and developing the workforce includes professional regulators but does not include professional bodies. Professional bodies are included within the MEE sector of the framework however it is important to recognise the vital and valuable role that the professional bodies will play in planning and developing the workforce. GPhC, the regulatory body for pharmacy, is responsible for ensuring safety and minimum standards within the profession however the RPS, as the professional body for pharmacy, is best placed to lead on professional standards for education and training and professional development. We believe that professional bodies, including the RPS, have a vital role to play in these proposals and should be included in the new framework.

Chapter 5

5.1 The consultation makes it clear that the responsibilities for planning and developing the workforce apply to all providers of NHS funded care. Greater clarity is needed however on how the proposals would be implemented and developed for private providers of NHS services such as community pharmacies, secure environments, private clinics and hospitals etc.

The consultation states that healthcare providers have an obligation to plan thoughtfully for the whole workforce however it is vital that this obligation is measured and monitored and that mechanisms to address the situation are available if this obligation is not met.

5.4 The consultation states that “individual employers” are best able to plan and develop their own workforce. However for small providers, such as independent pharmacies, this may not be sustainable and working with other local providers may conflict with commercial considerations.

5.5 Further detail is required on the “incentives” that are mentioned. It is unclear what these incentives might be and how these will be decided and allocated. We agree that multiprofessional training for commissioned services will be helpful to avoid under or over supply of suitable trained staff to provide services.

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?

Careful consideration needs to be given to how smaller providers of NHS care should be expected to engage locally. This may prove onerous for small providers such as independent community pharmacies. For example a small independent pharmacy, which may only employ 4 or 5 staff, should not be expected to consult with the public and commissioners on their workforce development plans. Consultation with the public and commissioners may be preferable at a regional or national level or smaller employers could be exempt from this requirement.

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

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

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

We believe the duty to provide data and the duty to cooperate is very important however we are unclear how this will work in practice. Clarity is needed on who will act or be responsible for poor compliance on this issue. It is vital that compliance with this duty is supported by electronic solutions and that this does not become unnecessarily onerous. The RPS would be concerned if the direction of travel is towards more market-based approaches, then the workforce is a key commodity and it is unclear how this sits with a collaborative approach to

training and education. There is a need to ensure that we have a variety of types of pharmacy education available and schools of pharmacy delivering the best education, and this may not be supported by a market-based approach. Variability in the production of the numbers of novice pharmacists, for example due to opening/closing of schools of pharmacy and re-adjustments of intake as the HE economy changes, may result in the scarcity of junior pharmacists which could present significant challenges. There is already a shortage of junior hospital pharmacists and problems also exist in some areas in community pharmacy. What are the incentives for health care providers (many of which in pharmacy are share-holder driven rather than public bodies) to cooperate? Commercial considerations regarding data collection and workforce planning will be important for private providers such as those found in community settings or future Foundation Trusts. Pharmacy includes many smaller, private providers, e.g. small independent community pharmacies, who employ very small numbers of staff and workforce planning, including data provision, will be unnecessary and onerous for them. We therefore believe that this model may not be appropriate for all the healthcare professions and may need to be adjusted for pharmacy. The pharmacy profession is very different in this respect to for example the medical profession which should be considered when developing the proposals. For smaller professions, such as pharmacy, it may be more appropriate for the data and planning to be considered at a national rather than individual provider level or via pharmacy representative groups.

The needs of pre-registration pharmacists must be considered alongside clinical placements for other healthcare professionals; a multiprofessional approach would be welcomed. It is important however that the problems already existing with finding sufficient pre-registration placements are not exacerbated by the proposals; smaller employers in particular may find it difficult to release staff for placements. This should be led by the professional bodies working closely with the higher education providers – the RPS would welcome this approach.

Joint education and NHS posts for the pharmacy profession could be a solution and this would need to be part of a defined career structure to ensure that quality and standards are ensured.

The needs of self-employed and locum healthcare professionals, including pharmacists, also need to be considered. It is unclear throughout the consultation document how these proposals will impact on these staff and how they will access or receive funded training and education. The needs of non-patient facing pharmacists also need to be considered. It is unclear how their training and education needs will be met however their roles underpin future and current healthcare provision.

If the data collected is used for workforce planning it is vital that quality and accuracy of the data is ensured. There may also be issues with workforce planning for specialist healthcare professionals as the data collection may not be sophisticated enough to ensure workforce planning at a specialist level.

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

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

The RPS is concerned that some of the LSNs are too large (e.g. in London) which may mean that they are unwieldy and unresponsive and not in any way an improvement on current models of delivery. The functions outlined for healthcare provider skills networks will require significant management and administrative support and premises and other resources will be required. It is unclear how this will be provided or funded. There may be a need for regional representation, bridging the gap between the local and national level, to ensure efficiencies and reduce the administrative burden for both LSNs and HEE.

We have additional questions as follows:

- It is unclear how HEE will manage LSNs if disputes arise. It may be that this role could be devolved to the professional representative bodies.
- How will funding be identified? On what basis?

The relative contributions of different professions will need to be carefully considered. For professions such as pharmacy this will need to be carefully calculated to ensure local and national needs are met. There is also a risk that large local employers, e.g. Trusts, will lead to the needs of secondary care dominating education and training provision and the needs of primary care may be overlooked. There may be a role for the professional body, to manage or coordinate this on behalf of HEE/LSNs and this may be more cost effective for pharmacy. However we also recognise the need for localisation and there is a strong evidence base that exists in pharmacy for local adaptation of services for the benefit of local patients and so an interplay between local and national networks would be beneficial. The RPS could support this via our local and national networks including specialist groups and local practice forums.

Local variation may cause problems for large national companies, such as those that exist within community pharmacy, who currently plan and deliver training at a national level across their organisations.

5.22 It is proposed that skills networks will be owned and funded by all providers within a locality however it is unclear how this will impact on private providers such as community pharmacy. How will costs, including administrative costs, be allocated and shared. The consultation specifies that GPs would need to be included however we believe that it is vital that pharmacy involvement is also mandatory.

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?

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?

Consideration will need to be given to the engagement with LSNs and there will need to be opportunities for central and local engagement with the professions. As the custodians of professional standards (above minimum regulatory competencies) the RPS is ideally placed to support employers and employees and ensure retention of specialist knowledge and skills for delivery in a constant and equitable way across the country (and subsequently, GB)

Private providers may prefer to “opt out” of local skills networks and provide their own training and development for their workforce. Provision of high quality, accredited training by private providers could result in a reduced levy to ensure employers were not paying twice. Accreditation could be carried out by the professional bodies.

Chapter 6

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

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

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

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?

HEE will provide important oversight of the Local Skills Networks but with limited resources the RPS has concerns regarding the level of involvement of HEE and the levers it will have at its disposal to address any emergent issues. The consultation proposes that HEE will be able

to hold skills networks to account, it is unclear how this will be enforced. We feel it is vital that mechanisms are in place to ensure all healthcare professionals can engage at a national and local level with local skills networks. There may also be regional differences which a national overarching body such as HEE will be unable to accommodate.

The proposed functions for HEE include engaging with the professional regulators on the alignment and development of standards and training however the regulators focus is on minimum standards of practice. We believe it is essential for HEE to also engage with the professional bodies, which includes the RPS, to ensure that education, training and development are able to support and enable improved services to patients and the highest possible standards of professional practice. In addition, the RPS is able to ensure that excellence and innovation are built into education and training support across the various sectors of practice and work settings.

The RPS welcomes the role of HEE in securing effective commissioning of education and training for smaller professions, including pharmacy. There may be a role for HEE to commission national training programmes for the pharmacy workforce to ensure delivery of services can be maintained across geographical boundaries. We support the remit of HEE as a multi-professional body and we believe it will be important for HEE to be given responsibility for the education budget. However we believe it is important to clarify further the relationship between HEE and the LSNs.

We believe it is vital that quality assurance mechanisms are assessed throughout alongside systems of quality management i.e. that the QA processes are equitably managed across all sectors to benefit service provision.

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?

We believe that the LSNs will need to form relationships with others including all employers, CfWI, sector skills councils and it is also vital that there is representation from national representative bodies such as the professional bodies. We believe there will also need to be a mechanism for the professional bodies to form a meaningful relationship with CfWI. For example professional bodies, such as the RPS, can provide valuable input and engagement in areas such as professional advice, scenario planning and benchmarking. This input, engagement and expertise is essential for accurate workforce planning to ensure sufficient numbers of trained and competent staff across the healthcare workforce including specialist and advanced practitioners. It will be important to plan ahead to ensure that the needs of the future workforce and future service delivery are reflected.

We welcome better workforce planning and the responsibility of the Centre for Workforce Intelligence and LSNs. However it is important that their functions are well integrated. For pharmacy, we would strongly urge national oversight, with special attention to ensure the needs of specialist training and groups are met as well as the needs of the generalist professional. As the professional body we believe that we are able to provide valuable input and expertise to ensure this is achieved. It is also important for the non-NHS workforce requirements to be considered to ensure that these can integrate with the proposals. The workforce needs of private providers and the roles of self employed professionals such as locum pharmacists will need to be included as well as pharmacists working in regulation and academia. Sufficient numbers of pharmacists working in academia will be required to ensure the proposals can be delivered. It is important to ensure that the evidence collection is robust and that data on all healthcare providers is included including private providers, self employed and locum healthcare professionals. The current system relies on overseas students both to subsidise pharmacy education in the UK and to work within the healthcare system. Adequate

workforce planning and education provision should ensure that the reliance on staff trained overseas is reduced.

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

It is vital that plans are not dominated by the needs of the larger professions or by individual sectors. It is vital that the needs of smaller professions, including pharmacy, and all sectors of healthcare practice are represented and included.

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?

The consultation describes the role of healthcare professional regulators however it is also important to consider the role of the professional bodies who have a vital role to play in developing and leading on improvements to professional standards and professional practice. Commercial confidentiality is vital for private providers and this must be taken into account when developing and enforcing these duties. If data is collected the purpose of the data collection and information about how the data will be used and shared must be transparent.

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

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

We welcome the new focus on the wider healthcare team and support for smaller providers however the role of the sector skills council in the new proposed framework is unclear.

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

We welcome the opportunity for the RPS to work in new ways to collaboratively support innovation and improvement in education and training. We also welcome the opportunity to work across traditional professional boundaries and will work closely with the medical Royal Colleges to provide multi professional clinical and professional leadership.

Many specialist pharmacy groups exist, both locally and nationally, and we believe that these groups, with the leadership of the RPS and other national organisations such as UKCPA, will be well placed to provide clinical leadership. The RPS works with experts across the profession via HEIs, specialist groups, professional forums, advisory panels and local networks of pharmacists (local practice forums) and so is ideally placed to facilitate and lead local and national engagement with clinical leadership.

The RPS is unlike specialist Royal Colleges, but there are clear and strong similarities around leadership, advocacy, enablement and support that the RPS provides to members across the entire pharmacy workforce. The RPS is the guardian of professional quality and standards and the promoter of excellent patient care across the profession.

The RPS works to encourage and enable pharmacists to undertake further education, training and development so that pharmacists are equipped with the skills they need to respond to healthcare changes in a nimble way. We work with partnership organisations and groups to enable pharmacists to access support and guidance and development opportunities to deliver services in a changing healthcare arena and to play a demonstrably beneficial role in patient care and public health.

Many existing professional networks are involved in education and training provision. The RPS has developed a network of Local Practice Forums (LPFs), which engage with pharmacists from all sectors across local communities. LPFs are identifying practice

developments linked to training needs and provision and encouraging practice research to provide the evidence base.

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?

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

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 agree that it is vital that leadership and management development for healthcare professionals, including pharmacy, should be included in the education and training system. Non-patient facing and non-clinical professionals are vital to underpin and lead current and future healthcare delivery. It is important that smaller professions, such as pharmacy, are included in plans to develop leadership capabilities and believe this is an ideal opportunity for multiprofessional training and development of healthcare professionals.

Chapter 7

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?

We agree that public health should be integrated within the new framework. Pharmacists and their staff, in all sectors of the profession, have a vital role to play in public health and it is important that pharmacists are considered as part of the multiprofessional workforce strategy for public health. We note that PHE will have an interest in the standards and quality of training and education of staff delivering commissioned services and would welcome the opportunity to work with PHE in developing those standards.

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?

We agree it would be useful for local authorities' views to be considered, as commissioners of public health services, however this could be achieved via other routes. It may not be appropriate to include local authorities within the skills networks or fund them via a levy as they will be commissioners of services rather than providers.

Chapter 8

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?

It is vital that the proposed levy on healthcare providers is fairly and carefully calculated to ensure that private providers and smaller providers are not contributing disproportionately and that their financial contribution is reflected in useful and appropriate education and training. Some private providers may wish to opt out of the levy and provide their own accredited education and training for their workforce in return for a reduced levy. There are already many private providers who provide good quality training and education and this needs to be considered when developing the proposals. We agree that the needs of the whole workforce should be considered including pharmacy support staff. We agree that the funding system should be fair and transparent and provide more opportunities for multiprofessional training and education.

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

It is proposed that MPET funding should be used only to fund education and training for future staff. This implies that current employers must fund investment in E&T for their current workforce which may lead to inconsistencies for healthcare professionals working in different sectors. We believe that it is vital that the process of change is managed as seamlessly as possible and that the delivery of training and education to existing staff is continued so that services are maintained across the sectors. This should include technician and support staff to ensure that skill mix is maintained and that efficient use of appropriate staff is ensured.

The RPS believes that it would be wrong to over localise pharmacy training and education because of the relatively small size of the undergraduate pharmacy pool. We risk creating a large number of sub-critical mass Schools of Pharmacy that cannot retain the quality of staff and investment required for the future.

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

We believe there is a risk that the postgraduate education funding streams will become confused – it is likely that HEFCE policy will move towards withdrawal of support for taught postgraduate programmes, although detail on this may not be known until May 2011. Continuing pharmacy E&T (in the NHS sectors) would be affected by change of support, and a clear future planning process would be essential. Taught postgraduate programmes have historically had a lower uptake from pharmacists working in the community sector and it is important that the needs of all sectors are considered when considering funding streams to enable professional development, skill mix changes, innovation and continuous improvements to patient care across all sectors.

A plan for establishing undergraduate/postgraduate pharmacy deaneries functions (either within existing medical deaneries or within skills networks if these take on the role of deaneries) ought to be started in advance of the outcomes of Modernising Pharmacy Careers. We believe that there should be a greater emphasis on the role of higher education and its relationship to pharmacy workforce development. There will be a need for HEIs to become more responsive and innovative in provision and partnership working.

Ring fenced funding will be necessary to support innovation. Funding for new roles, such as non-medical prescribing, will need to be protected to ensure that new innovative roles and delivery mechanisms can develop.

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?

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?

The RPS supports greater transparency in the area of tariffs and would welcome the opportunity for us, as the professional body, to be involved in ensuring that this tariff is linked to quality.

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

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

The RPS would need to be assured of (and can help with developing) the checks and balances that need to be in place in such a market of commissioning, funding and delivery of education and training.

We have concerns regarding how the resource levels for post registration education and training will be agreed and would recommend that representatives of the pharmacy profession, including the professional body, are closely involved in these further negotiations and discussions.

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

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?

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

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

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

We believe it is vital that the funding models are carefully considered. The RPS is concerned that, without due care and attention to the detail around this and the management of funding, these proposed changes will be very hard to implement effectively and this could impact negatively on patient care. It is vital that funding models are fair and transparent across all professions, sectors and models of care. There should be incentives to encourage organisations to engage with workforce development. The use of levies for healthcare providers would need to be very carefully considered to ensure that this was reasonable, fair and considered for commercial accountabilities and sensitivities. A national levy may be preferable and will reduce bureaucracy. It will be very difficult to calculate a levy for organisations that are providing NHS and private services.

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

We would request that representatives of the pharmacy profession, including the professional body, be involved in the further discussions and negotiations around quality metrics.

Chapter 9

Q41: What are the challenges of transition?

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

Q43: What support systems might they need?

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

As the professional body, we welcome reform to ensure the pharmacist (and the wider pharmacy) workforce is appropriately knowledgeable and skilled to deliver patient care and public health in a changing healthcare system. However, we would like reassurance that the interim arrangements are robust enough to ensure smooth migration from the current system to the proposed new system over such a short timeframe.

We also believe such a major redesign of the whole system carries certain risks. For example, there is the risk of other important developments and improvements to healthcare services being delayed during the transition period as the focus of those people and organisations involved is diverted; and there may be unforeseen consequences of some of the changes. For example if the wrong incentives were introduced this may have the result of favouring short term considerations unduly over the interests of the longer term. There is also a risk that, at this time of great change, expertise and organisational memory will be lost. In view of these

risks, the transition period will need to be well resourced and to be managed with considerable care. The NHS should have a duty to current employees to assess the skill mix of those currently employed in the NHS and provide the necessary training and education to enable the current work force to change direction if necessary and update skills so that they have the relevant skills going forward.

The healthcare workforce, including pharmacists, are currently facing a great period of change. Transition arrangements for these proposals need to be considered alongside the other proposed changes to the NHS and public sector. It will be important to consider that this will be a difficult time of change for pharmacists working in education in the HE sector, including those actively delivering education and training to preregistration pharmacists and those delivering various forms of education and training to post graduate pharmacists. Pharmacists working in strategic health authorities and PCTs are already working to navigate huge changes to their roles and functions and this should be considered when planning transition arrangements for workforce development.

Chapter 10

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

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?

The needs of all staff, including part-time and temporary staff as well as staff on maternity leave or a career break, need to be taken into account in the development of these proposals to ensure that no groups or individuals are disadvantaged. The proposals should ensure that widening participation to training and education is encouraged to ensure equal opportunities for individuals of all backgrounds. In order to ensure that financial barriers to education and training are removed there may be a need for bursaries to continue in some form.

General comments

There have been many changes to the way in which training is funded over the last 20 years and this has resulted in a complex system. We believe the new system should

- Ensure a greater transition and link between undergraduate training and the workplace
- Connect the whole pharmacy workforce
- Ensure pharmacy training is linked into the rest of the healthcare team
- Involve pharmacists in the training of other healthcare professionals
- Ensure the practice arena is better able to provide educational support for practitioners
- Ensure all healthcare professionals benefit from the funding streams available
- Work with the professions to maintain and oversee a credentialing scheme that maintains standards and quality

Conclusion

The RPS believes that there is a need to ensure that provision of education, training and professional development mirrors the patient journey and that emphasis is placed on service delivery across the sectors from primary to secondary and tertiary sectors, whilst

acknowledging the huge changes underway in the way care will be delivered, monitored, commissioned and funded. It is vital that workforce planning and development accounts for the entire workforce delivering services in the NHS including small providers, private providers and self employed healthcare professionals as well as considering the numbers of healthcare professionals needed for other roles such as regulation, academia and industry.

The NHS is attempting to make 4% efficiency savings per year over the next four years whilst the demand for health services is increasing due to an ageing population and associated health burden and increasing complexity of medicines. In taking these factors into account alongside the proposals of the consultation paper we have concerns about the pace of change and how the demands of the proposed timeline will be managed.

The RPS supports the principles of the consultation paper; however we believe that there is insufficient detail and clarity on how provision will meet demand. We have concerns regarding long-term planning and how service integration will occur. We also feel that there is a lack of clarity about new roles, e.g. for doctors, pharmacists etc, and subsequent advocacy and engagement with LSNs. We believe it is vital that there is appreciation of the unique education and training needs for each profession and it is important to consider inter-professional education as well as multidisciplinary working. Education foundations for the development of "expertise" in addition to CE and CPD are important and should be considered alongside acquisition of role based skills.

The RPS has concerns about exactly how the proposals might work in practice e.g. the coordination functions, accountability pathways and professional representation. We seek further clarity on these areas and request that the views of the professions are sought and considered as the proposals are further developed.

The RPS welcomes reforms that enable the healthcare workforce, including pharmacy, to develop and deliver services to patients responsively but we call for greater consideration and clarity around the detail of the proposals. This must be achieved before further roll out in order to ensure that the lack of detail does not negatively impact the delivery of the proposals.

Kind regards,

A handwritten signature in black ink, appearing to read 'C Duggan', with a long horizontal stroke extending to the right.

Catherine Duggan PhD FRPharmS
Director of Professional Development & Support