**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

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

This is the status quo option. No control of entry to the profession i.e. no policy interventions are made. The system will rebalance itself over time as it is likely that market demand for MPharm student places will decrease as the number of unemployed pharmacists increase (and/or pharmacists' salaries are adversely affected by market forces).

**Patients:**

- Potentially damaging to patient care as the quality of pharmacists may not be maintained;
- Modelling by the Centre for Workforce Intelligence claims that in the short to medium term there will be an oversupply of pharmacists which will turn into an undersupply of quality pharmacists in the long term thereby putting at risk the potential for pharmacists to contribute to the pharmaceutical care of patients and the optimisation of their medicines;
- Does not take into account the views of patients.

**Students:**

- May force MPharm graduates to undertake pre-registration training at a wage much lower than the current one thereby reducing costs to employers as greater competition could drive down wages but students may therefore have to secure further loans in this period;
- Retention of existing arrangements of a split pre-registration year e.g. for students wishing to experience the pharmaceutical industry and academia;
- Cannot guarantee MPharm students will be able to secure a pre-registration trainee pharmacist placement in the UK;
- Increasing numbers of students graduate with large debts (of at least £50K (though may be higher if the student is living away from home and can claim the maximum available loan)) are unable to secure pre-registration placements or find that there are no jobs available subsequently thus the return on investment (ROI) in their education is negative.

**Employers:**

- Eventual decreased popularity of the pharmacy profession as a career with decreasing applications from more academically able students and therefore potentially damaging to the profession/employers;
- Does not take into account the views of employers;
- May force MPharm graduates to undertake pre-registration training at a wage much lower than the current one thereby reducing costs to employers as greater competition could drive down wages;
- Increased competition for pharmacy positions in the short-term could provide employers with opportunities to select the best quality graduates;
- Increased competition for pharmacy positions may cause some of the most able undergraduates to retrain in another career (e.g. medicine) and not enter the pharmacy profession.

**Universities:**

- Destabilisation of pharmacy education in the Higher Education sector as Vice Chancellors would not invest in pharmacy education as not seen as a good investment (due to market demand for student places having decreased over the medium to long term) leading to closure of some schools of pharmacy;
- In the short-term, schools of pharmacy will face competition for quality applicants which could increase the quality of courses offered;
- Universities would be unable to fill places in schools of pharmacy in the longer-term even if poor quality applicants (lacking the correct knowledge, skills and attitudes) are accepted.

**Other stakeholders including government:**

- Easy as no policy intervention is required;

- Slowest option as the system will take time to rebalance itself (estimated to be 5-10 years);
- Does not adhere to Department of Health policy i.e. does not fit with Modernising Pharmacy Careers (MPC) Workstream I proposals for a 5-year integrated degree;
- Government does not 'secure the students' interest' i.e. support widening participation;
- Inflexible as relies solely on a market approach leading to other unknown consequences;
- The NHS could be exposed to extra costs if there is no limitation on the pre-registration grant paid via the General Pharmaceutical Services contract;
- Due to the potential for under-supply in the long-term (see under patients) this does not support flexing the pharmacy workforce to cover aspects of current roles that are experiencing shortages e.g. General Practitioners and nurses.

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?

To be fair to applicants to schools of pharmacy, so that they can make an informed decision, it would have to be made clear the proportion of graduates that are able to secure preregistration places and practice as pharmacists in future. Currently, the Unistats web site for individual pharmacy courses (http://www.unistats.ac.uk/) lists average salaries 6 months after completing the course rather than state the likelihood of securing a pre-registration placement (though figures are available for how many students go on to employment or further study). The BPSA study on student intentions on graduation (First year Student Survey, British Pharmaceutical Students Association, January 2013) indicated that almost all MPharm students wished to practice as pharmacists on graduation, pharmacy being no different to medicine or dentistry in this respect. The introduction of a managed web-based "clearing house" covering all sectors and detailing employment statistics and trends over a number of years could provide further support to students.

Highlighting potential employment problems in pharmacy could make other career routes appear less risky, although in reality, the best students may still be able to secure pre-registration positions. The highest quality applicants will have numerous other opportunities and may choose other less risky courses even though their prospects in pharmacy would be good. It would therefore be important to give comparative statistics with other degrees and professions.

Ideally, applicants would be told the number of DH/HEE funded pre-registration places that will be available to their cohort. This would require a commitment from DH/HEE at least 5 years before the posts are required, and allow HEFCE, HEE and Schools to publish predicted employment rates based on previous data.

## 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.

**This is the RPS's preferred option.**

This option provides an opportunity to increase the quality of pharmacists to meet: patient needs, professional responsibilities and deliver innovative services. A quality driven allocation of student numbers to schools could lead to competition in the sector and a strong incentive to enhance pharmacy courses. A future integrated 5 year MPharm offers the opportunity to select the best students.

To strictly control one part of the HE system for pharmacy training and leave Wales and Scotland relatively uncontrolled could distort training of pharmacists in the UK leaving English universities to bear a reduction in funding.

The number of UK/EU students undertaking the MPharm degree via an intake control mechanism must be linked to numbers of pre-registration training places, which would be adjusted according to workforce demand. There is a risk of an increasing mismatch between graduate numbers and training places if the link is not made. All employers would need to commit to providing pre-registration trainee pharmacist placements at least four years in advance i.e. when students apply to the course (this could be managed through learning agreements between education commissioners and employers). HEE currently mandates that all medical school graduates will get a Foundation year placement – a similar mandate would be needed for pharmacy pre-registration trainee pharmacist placements. Commercial organisations can go out of business in 4 years (or business priorities may change) and Universities will also need to plan for intakes, so the system would need to be carefully managed with contingency plans in place. The number of students and pre-registration trainee pharmacist placements would need to be agreed. A similar approach could be taken that currently exists for medicine and dentistry. Health Education England (HEE) and the Higher Education Council for England (HEFCE) could share responsibility for determining the pharmacy school undergraduate intakes in England with HEE responsible for determining overall numbers and HEFCE having responsibility for distribution to pharmacy schools. Similarly, a group similar to the Health and Education National Strategic Exchange (HENSE) could periodically review the numbers of pharmacy school places required in the future in order to discharge HEE's and HEFCE's joint responsibility.

As Pharmacy Schools would need to restrict their current intake of MPharm students, this approach will require careful transitioning from free market to a managed market. The expedient approach (as currently followed by medicine and dentistry) would be to set a goal of a small oversupply of MPharm students to pre-registration places to provide contingency and competition to maintain the quality of pharmacy graduates. The number of pre-registration places will be based on demand for the pharmacist workforce with undergraduate numbers being adjusted accordingly. Although it is also important to consider geography i.e. what are the local needs and the right numbers of schools in an area; for example, there are 4 schools of pharmacy in the West Midlands but only one in the South West of England (Bath), quality should be the over-riding criteria for the accreditation of a school of pharmacy. First post destination data could be used to ascertain the level of local recruitment of pharmacy graduates from schools of pharmacy. This is also an important consideration for MPC Workstream I i.e. the availability of local clinical input and placements for years 1-3 of the proposed new arrangements.

**Patients:**

- It is more likely that pharmacists of a consistent quality are produced by this option because the focus will be the quality of pharmacy graduates rather than the quantity;

- The linking of numbers of undergraduate places to the number of pre-registration placements will allow clinical skills and professionalism to be built in from the very start.

**Students:**

- Restricted numbers of MPharm places with a greater likelihood of securing a pre-registration placement and subsequent employment could make places on MPharm programmes more sought after and should increase the quality and quantity of applicants in a sustainable way;
- The number of MPharm places allocated to each school of pharmacy would need to be based on agreed quality criteria so that high quality students have the opportunity to learn at universities that are highly rated for teaching and research. A uniform cut of intake numbers across all current and future schools of pharmacy could inhibit quality improvement and innovation because of the risk of creating a protectionist environment whereby there could be less incentive for some schools of pharmacy to invest in the best staff, teaching and research facilities. Ambitious students who did not secure a place in a highly rated university could apply to do different courses rather than complete a pharmacy degree at a university they did not wish to attend. This would leave vacancies for less able students and the quality of pharmacists could decline. Measuring the quality of teaching and research at schools of pharmacy and the quality of the graduates/pharmacists emerging will need very careful consideration.

**Employers:**

- Commercial organisations could go out of business in a short period of time thereby depriving the system of pre-registration placements so employers would have to commit to places 4 years in advance;
- Overall employers could benefit from a predictable supply of high quality graduates with the right knowledge, skills and attitudes.

**Universities:**

- Allow selection specifically for potential pharmacists who are academically able (rather than current pressure to fill all student places) with the right knowledge, skills and attitudes required for professional practice;
- Potential to widen participation through more locally commissioned education;
- Numbers of students could be based on quality indicators and used to drive up quality (quality indicators would need to be agreed and measured effectively);
- Would most probably result in reduced viability for some schools of pharmacy;
- Would significantly reduce revenues for some universities;
- High quality research-led teaching HEIs offer an international educational environment meaning that UK pharmacy education is highly sought after and this is likely increase if allowed to prosper. There is a responsibility to maintain this and whilst UK courses are rightly geared to the generation of pharmacists for future employment in the UK, this is not the only or ultimate destination for all students.

**Other stakeholders including government:**

- This approach is consistent with MPC Workstream I;
- Opportunity to equilibrate the disparity in funding received by NHS and community pre-registration places;
- Recruitment for attitudes, behaviours and values on entry to MPharm could be incorporated (a key action from the Francis Inquiry);
- Would take several years to achieve as a transition period would be needed so not an immediate 'fix';
- More able to manage to the pre-registration trainee pharmacist placement costs associated with the General Pharmaceutical Services contract.

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

As with medicine and dentistry, Health Education England (HEE) and the Higher Education Funding Council for England (HEFCE) should share responsibility for determining pharmacy

undergraduate intakes in England. The constitutional position would be that HEE would be responsible for determining overall numbers based on latest workforce intelligence and HEFCE would be responsible for the individual distribution to schools of pharmacy.

Criteria would be quality indicators including:
1. Entry qualifications of students;
2. General Pharmaceutical Council (GPhC) Registration Exam results and achievement of performance standards should inform selection. These would be averaged over a 5 year period;
3. GPhC Accreditation of MPharm programme outcomes;
4. Research quality as evidenced by HEFCE REF2014 exercise or similar;
5. Investment over the last 5 years in staff and infrastructure;
6. Evidence of innovation and quality in the MPharm programme;
7. Feedback from employers.

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

International students pay the full cost of their degree. The UK is recognised as a world leader in higher education and although overseas (non-EEA) students contribute significantly to the costs of their university education, in some instances they still generate costs, especially in relation to clinical placements (there is a limit on the capacity of the NHS and providers of NHS services to provide clinical placements). Some international students will wish to undertake their pre-registration year elsewhere and leave the UK on graduating, some will wish to complete this in the UK, register with the GPhC and then go on to work elsewhere, and others will wish to work in the UK as a pharmacist. To secure a pre-registration training placement, current Home Office immigration rules require overseas MPharm graduates to apply for a Tier 2 graduate visa if they achieve a pre-registration training placement with a salary of £20,300 or more per annum (as is the case with NHS pre-registration placement salaries) or go through the RPS's Pharmacy Professional Sponsorship Scheme (apply for a Tier 5 visa) if the salary is below £20,300 per annum. The sponsorship scheme is an interim measure and eventually Tier 2 will be the only route to a pre-registration training placement unless schools of pharmacy offer an integrated 5-year course operating under a student visa.

Considering the above there cannot be unlimited access to overseas students to pre-registration funding given the financial consequences to the NHS. If international students return to their home countries, this could be regarded as an unnecessary drain on scarce NHS resources.

Placing limits on the intake of international students on MPharm programmes could have an adverse impact on a number of schools of pharmacy leading to a significant reduction in revenue and their international reputations put at risk. International students could simply train in the devolved nations (i.e. Northern Ireland, Scotland and Wales or in Europe and further afield) thereby distorting the Higher Education market in the UK – or they could not train in the UK at all with the result a negative impact on the UK economy. If international students were to be excluded from MPharm student number controls, the number of successful graduates who obtain a pre-registration placement in the UK (assuming a successful visa application and a high proportion of self- financing graduates) must be carefully managed so as not to displace GB students from placements. This will need careful consideration and planning.

## 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.

This proposal is not consistent with the work of HEE (and MEE) over the last 5 years to establish an integrated 5 year programme. It is possible that concurrent degree programmes could be run – a BSc followed by selected progression to an MPharm. Selected progression would need to be based on agreed criteria e.g. level of BSc degree awarded and attainment of the right attitudes and behaviours. Clarity would be needed as to where GPhC standards apply in the curricula. Another possible break point could be considered after year 2.

**Patients:**

- The current curriculum (following guidelines from the GPhC) integrates clinical and professional context with science from the start with public and patient safety the prime concern – this makes identifying a break point difficult;
- Undergraduates entering years 4 and 5 can be assessed for the right values, attitudes and behaviours thereby implementing the Francis Report's actions and ensuring compassionate pharmaceutical care.

**Students:**

- Undergraduates entering years 4 and 5 can be assessed for the right values, attitudes and behaviours (thereby implementing the Francis Report's actions);
- Students incur significant debt and may not end up with their first choice degree i.e. a BSc rather than an MPharm;
- Could be attractive for those students who are undecided about their future career (though current evidence suggests this is a small minority approx 2%);
- Produces scientifically literate graduates for employment in other areas of the bio-tech industry;
- Validity of BSc (for example, a career in pharmaceutical industry) would not be as strong as an MPharm as pharmacists' professional training is valued by employers;
- This model will look very different to every other model of healthcare professional education so students may apply for other courses where progression to a professional role is more certain.

**Employers:**

- Could change the nature of the MPharm student intake (currently all students entering an MPharm expect to become practising pharmacists) and there could be unintended consequences with the quality of the MPharm graduates produced.

**Universities:**

- Widens participation;
- Government does not 'secure the students' interest' risking reduced engagement with the degree;
- Further implementation of a spiral curriculum to reinforce clinical skills and professionalism may be more difficult as years 1-3 may need to be made to be more generic in order to create a break point during study;
- Unpredictable effect on the universities' business models;
- Financing for clinical (Band A HEFCE) funding more realistic if it is confined to after the breakpoint (but this makes delivery of a spiral curriculum that includes early clinical placements from the start more difficult);
- There could be a better understanding of students' aptitudes at the break point (compared to at age 17/18);
- Applying fitness to practise and professional conduct procedures could be problematic with those students who do not go onto become a pharmacist;
- Would take a long time to implement.

**Patients**

- Undergraduates entering years 4 and 5 can be assessed for the right values, attitudes and behaviours thereby implementing the Francis Report's actions and ensuring compassionate pharmaceutical care.

**Other stakeholders including government**

- Could align with some other European models e.g. 'Scandinavian' approach;

- Could provide a shorter turn around for controlling numbers as the timeline for the supply is 2 years compared to 5 years assuming the control of entry would be to the 2 year top up Masters.
- It is not consistent with MPC Workstream I proposals including clinical funding (but the curriculum could be adapted to fit);
- Negative return on investment for any clinical training undertaken in years 1-3 for those students who do not progress to an MPharm;
- This approach does not mirror that of established and effective approaches of other healthcare professions e.g. medicine and dentistry and alignment makes the best use of public money;
- This model does not currently fit with GPhC standards for the initial education and training of pharmacists.

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

The new highly integrated curriculum with clinical and professional context (following guidelines from GPhC) taught from day 1 of year 1 offers no clear break point that would give an exit degree of value.

It would be possible to run concurrent degree programmes (BSc) and selected progression towards a 2 year top up Masters (MPharm) in order to fully register as a pharmacist. However see points above.

Another break point could be considered after year 2 (following the medical model).

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

If this option was applied, the approach could be summative assessments including values, atttitudes and behaviours. See points above. Control mechanisms are already in place within the Schools of Pharmacy in the form of end of year assessments, although these are local to the individual schools rather than being national assessments.

## Overarching questions

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

Under the modernising pharmacy careers workstream 1 proposals (Modernising Pharmacy Careers Programme. Review of pharmacist undergraduate education and pre-registration training and proposals for reform. Report to Medical Education England Board, April 2011), the case for the current pharmacy education programme no longer being fit for purpose is well made. Their proposals make pharmacy degrees more like other healthcare professional Higher Education courses, with integrated clinical placements within a 5 year programme. The integrated placement availability would need to match student numbers, as with medicine, dentistry, nursing etc., otherwise the course cannot be completed. If we follow the vision of the 5 year integrated course, then curriculum reform is critically important and long overdue. If that is achieved then a sustainable supply of high quality graduates with appropriate professional skills and attitudes are more likely to follow. The MPC 5 year integrated programme will hopefully control student numbers and enhance quality. Universities would require guaranteed placements and HEE/HEFCE could control the award of these to individual schools. The 5 year MPharm requires additional funding from HEE/HEFCE for each student and the award of this extra funding creates the required mechanism to control numbers to ensure the overall funding package is the same as it is currently i.e. cost neutral.

Another consideration for curriculum reform would be increasing the robustness of assessment on MPharm programmes thereby better ensuring high quality graduates. This would need care as high attrition rates could put off prospective high quality students but the curriculum should deliver high quality graduates in the right numbers.

Recommendations from the Francis Inquiry should be incorporated into the curriculum.

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 the majority of international students who wish to undertake their professional training in the UK, would need to fund their own preregistration 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 so capacity would need to be demonstrated. Schools of pharmacy would need to be able to arrange such progression routes that allowed tier 4 visas to be used, so integrated 5-year programmes would need to be developed to achieve this, following a model similar to that of the University of Bradford's 5 year degree programme.

NHS organisations and community pharmacies who can demonstrate capacity for training pre-registration pharmacists under the approach above, could share the income received by schools of pharmacy from the training of international students. It is more likely that capacity would come from the community sector.

This approach could be applied to options 1 and 2 but may not fit with option 3.

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?

Further work is needed to understand the impact of the each of the options on local health inequalities. Option 1 is unlikely to ensure needs are met as financial risks may be viewed as being too great.

Although it is important to ensure that local health inequalities and labour market conditions are addressed the most important factor nationally and locally is quality. Each school of pharmacy in the UK must endeavour to be rated as having high quality teaching and research so that they produce high quality graduates. The current academic pharmacy workforce is stretched with the proportion of pharmacists to non-pharmacists on the teaching staff reducing so opening new schools in localities without current provision could further compound the situation with the risk that quality of graduates is affected. Local education commissioners who face inequalities could link up with commissioners in a neighbouring locality (that contains a school of pharmacy) to ensure that needs are met.

Quality criteria could be created, linked to intake numbers (see response to question 4) and applied across options 2 and 3 as outlined above – as long as a school can meet these criteria, it can contribute to its locality. Otherwise local commissioning of pre-registration places (as described above) and other incentives may be required to increase the mobility of the workforce.

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?

The control of entry by 2015-2016 would be feasible.

To be fair to applicants and universities clarity would be needed over student numbers at least 1 year in advance of a limit being set. Interview cycles begin 10 months in advance of start of the academic year (marketing and engagement with prospective students begins much earlier, a minimum of 18 months) and universities would not wish to interview without a limit known. Universities also ideally need to know student numbers at least 2 years in advance in order to accurately plan marketing campaigns. The introduction of a break-point into existing 4 year MPharm programmes would require a major restructuring and reaccreditation of courses and would need at least 3 years' notice.

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

Option 2 provides the best opportunity to increase quality of pharmacists to meet: patient needs, professional responsibilities and deliver innovative services. A quality driven allocation of student numbers to schools could lead to competition in the sector and a strong incentive to enhance pharmacy courses. A future integrated 5 year MPharm offers the opportunity to select the best students.

Quality must be the prime concern at every stage – from recruitment/selection of students, throughout the curriculum, to the production of graduates and registration of pharmacists. Option

2 offers the best opportunity to ensure:

1) Patients' and public needs come first as they must expect to access high quality pharmacy services delivered by a flexible, adaptable, capable and competent workforce;
2) Pharmacists entering the profession are of the highest quality with the right skills, level of knowledge, values, attitudes and behaviours;
3) All education and training delivered to MPharm students and pre-registration trainees is high quality – grounded in science but contextualised in professionalism and clinical practice.

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

The RPS has considered a range of other options and undertaken a risk analysis for all options but considers that the associated risks and challenges of implementation would have an adverse impact for patients, students, universities, employers and other stakeholders.

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

The focus of this consultation should be to allow the education of the highest quality healthcare professionals to advance patient care. It should provide the basis on which universities, working in partnership with all the important stakeholders, are allowed the best means to achieve this.

Managing intake control will need accurate workforce planning based on robust workforce intelligence and the ability to flex workforce numbers in response to changing circumstances. The RPS believes that an iterative approach (where regular adjustments to the numbers of students and trainee placements are made based on the latest high quality workforce data and demand for pharmacy services) is preferable to a 'big bang' approach (for instance drastically reducing the number of training placements as a one-off exercise) which can cause large swings between over and under supply of healthcare staff. Thus, policy relating to planning the pharmacy workforce must consider the future roles of pharmacists and the skill mix of the pharmacy team in addition to the supply of pharmacists.

Current education arrangements are a 4-year undergraduate degree (Master of Pharmacy or MPharm – accredited by the profession's regulator, the General Pharmaceutical Council (GPhC)) followed by a separate year of pre-registration practice-based training leading to registration as pharmacist with the GPhC. The process of becoming a pharmacist is thus divided into two parts and completely separate in terms of curriculum, quality assurance and outcomes. This creates a gap in how the concept of professionalism is managed – MPC Work Stream I has made proposals to bridge this gap by changing pharmacist education to a five year integrated course with two 6-month placements (major placements) and concurrent graduation and registration. The progression to a 5-year integrated degree is supported by the RPS.

The RPS recommends that the GPhC makes the accreditation of MPharm programmes more robust by including standards for recruiting prospective students that includes an assessment of their desire and suitability to practice pharmacy that covers: skills, knowledge, attitudes and behaviours.

As the RPS is the professional leadership body for pharmacy in Great Britain it is important that

any discussions about ensuring a sustainable supply of pharmacy graduates (and the availability of pre-registration training placements) should be considered in the context of the whole geography of Great Britain. Future policy on the supply of pharmacy graduates in England must not destabilise the pharmacy labour market in Scotland and Wales.