# Council meeting

## Meeting of the 6 April 2017

11:30am to 2:30pm  
Council Room 1, 25 Canada Square, London E14 5LQ

### Public business

<table>
<thead>
<tr>
<th></th>
<th>Attendance and introductory remarks</th>
<th>Nigel Clarke</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Declarations of interest</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Public items</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Minutes of last meeting</td>
<td>Nigel Clarke</td>
</tr>
<tr>
<td></td>
<td>Public session on 16 March 2017</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Actions and matters arising</td>
<td>Nigel Clarke</td>
</tr>
<tr>
<td>5.</td>
<td>Standards for pharmacy professionals: additional consultation</td>
<td>17.04.C.01 Laura McClintock</td>
</tr>
<tr>
<td></td>
<td>For approval</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Consultation on revalidation for pharmacy professionals</td>
<td>17.04.C.02 Osama Ammar</td>
</tr>
<tr>
<td></td>
<td>For approval</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Chief Executive’s report</td>
<td>17.04.C.03  Duncan Rudkin</td>
</tr>
<tr>
<td></td>
<td>For noting</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Engagement and communications report</td>
<td>17.04.C.04  Rachael Oliver</td>
</tr>
<tr>
<td></td>
<td>For noting</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Policies and procedures reviews</td>
<td>17.04.C.05  Matthew Hayday</td>
</tr>
<tr>
<td></td>
<td>For approval</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Any other public business</td>
<td>Nigel Clarke</td>
</tr>
</tbody>
</table>

- **Public items** include discussions on matters not specifically restricted to public viewing, such as personal information and commercial information, but are not necessarily restricted to public items.
## Confidential business

<table>
<thead>
<tr>
<th></th>
<th>Declarations of interest</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td><strong>Confidential items</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Minutes of last meeting</td>
<td>Nigel Clarke</td>
</tr>
<tr>
<td></td>
<td><strong>Confidential session</strong></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Confidential actions and matters arising</td>
<td>Nigel Clarke</td>
</tr>
<tr>
<td>14.</td>
<td>Any other confidential business</td>
<td>Nigel Clarke</td>
</tr>
</tbody>
</table>

### Date of next meeting

Thursday, 11 May 2017
## Council actions log

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Ref.</th>
<th>Action</th>
<th>Owner</th>
<th>Due date</th>
<th>Status</th>
<th>Comments/update</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Mar 17</td>
<td>113.3.</td>
<td><strong>Business plan 2017-20</strong></td>
<td>Duncan Rudkin and Chair</td>
<td>6 Apr</td>
<td>Closed</td>
<td>Reflected in the amendments approved by the Chair.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Council suggested that the plan be re-drafted slightly to highlight aspects of seeking assurance that owners of pharmacies were delivering an environment where registrants could work professionally. Council were content to allow the Chair to sign off a re-draft following this meeting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Mar 17</td>
<td>113.4.</td>
<td><strong>Business plan 2017-20</strong></td>
<td>Duncan Rudkin</td>
<td>6 Apr</td>
<td>Closed</td>
<td>Reflected in the amendments approved by the Chair.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Members asked for explicit reference to political uncertainty more generally around Brexit and the potential for a second Scottish referendum throughout the plan. DR agreed that this would be integrated into the redraft.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Mar 17</td>
<td>114.4.</td>
<td><strong>Performance monitoring report</strong></td>
<td>Claire Bryce-Smith</td>
<td>7 Sep</td>
<td>Open</td>
<td>Analysis of panel member utilisation for Hearings will be undertaken and an update provided to Council in September</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Council requested more information on the scheduling of hearings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Minutes of the Council meeting held on Thursday, 16 March 2017 at 25 Canada Square, London at 10:00am

TO BE CONFIRMED 6 APRIL 2017

Minutes of the public session

Present

Nigel Clarke (Chair)    Joanne Kember
Sarah Brown    Evelyn McPhail
Mary Elford    Arun Midha
Digby Emson    Berwyn Owen
Mark Hammond    Samantha Quaye
Liz Kay

Apologies

Mohammed Hussain, Alan Kershaw, David Prince and Vivienne Murch

In attendance

Duncan Rudkin (Chief Executive & Registrar)
Matthew Hayday (Head of Governance)
Claire Bryce-Smith (Director of Inspection and Fitness to Practise)
Hugh Simpson (Director of Strategy)
Lyn Wibberley (Chief of Staff)
Chris Alder (Head of Professionals Regulation)
Rachael Oliver (Head of Communications)
Mark Voce (Head of Systems Regulation – Inspection)
Helen Dalrymple (Acting Council Secretary)
110. Attendance and introductory remarks

110.1. The Chair welcomed all present to the meeting. Council agreed that members would now make any declarations of interest before each item rather than at the start of the meeting.

111. Minutes of the last meeting

111.1. The minutes of the public session held on the 9 February 2017 were confirmed as a fair and accurate record.

112. Actions and matters arising

112.1. Council congratulated Digby Emson (DE), Alan Kershaw (AK) and Evelyn McPhail (EM) on their reappointment as Council members.

112.2. The Chair announced two new members who would be starting their appointment on the 1 April 2017: Elizabeth Mailey and Jayne Salt.

113. Business plan 2017-20

113.1. Duncan Rudkin (DR) presented 17.03.C.01, which asked Council to agree the business plan for April 2017 to March 2020.

113.2. DR highlighted and acknowledged para 2.4 of the paper which explained that not all work programmes were ready with a detailed timetable in place. Milestones and deadlines would fall into place as directorate and team plans developed and work progressed; these would be reported to Council.

113.3. Council suggested that the plan be re-drafted slightly to highlight aspects of seeking assurance that owners of pharmacies were delivering an environment where registrants could work professionally. Council were content to allow the Chair to sign off a re-draft following this meeting.

**ACTION:** DR and Chair

113.4. Members asked for explicit reference to political uncertainty more generally around Brexit and the potential for a second Scottish referendum throughout the plan. DR agreed that this would be integrated into the redraft.

**ACTION:** DR

113.5. Council asked for further details on how much would be saved through the service transformation key work stream and it was agreed that this would follow after further Efficiency and Effectiveness Advisory and Assurance Group (EEAAG) meetings. Council also noted that the delay of three months before reporting felt too long for two of the proposed quarterly reports.

113.6. DR agreed to bear this in mind and to commit to developing criteria to identify issues that needed to be flagged to Council sooner.
113.7. Council discussed the Equality, Diversity and Inclusion (EDI) work streams and agreed that timing was key and EDI remained a high priority.

113.8. Council approved the business plan for 2017-20, subject to re-drafting in line with the comments above that would be signed off by the Chair.

114. Performance monitoring report

114.1. DR presented paper 17.03.C.02, which reported to Council on operational and financial performance to the end of December 2016. In the ensuing discussion the following points were made:

Customer services

114.2. Members asked for clarification on the significant staff turnover in the contact centre, as reported at 1.4. DR explained that there was no unusual issue. A very stable management team had all started at similar times and had moved on to more senior positions in other organisations. Some junior staff had moved to other jobs within the GPhC which was a good indication of the availability of opportunities within the organisation. The team were now up to strength and this would be reflected in the next report.

Fitness to Practise (FtP)

114.3. Chris Alder (CA) informed Council that the last sentence of last paragraph of 2.1 should be amended to ‘Importantly the total number of cases closed at Stream 2, IC and FtPC all increased this quarter.’

114.4. Council requested more information on the scheduling of hearings. Claire Bryce-Smith (CBS) acknowledged that hearings had an extremely busy programme and agreed to provide more analysis outside the Performance Monitoring Report.

ACTION: CBS

Inspection

114.5. Members sought some assurance on how themes for improvement from inspections were communicated to registrants. Mark Voce (MV) explained that these were covered regularly in Regulate and discussed in meetings with larger multiples as well as organisations such as the National Pharmacy Association (NPA).

114.6. Council asked for more context to be provided in the report so that they could understand better what ‘good’ looked like and identify risks as they emerged. CBS stated that the new style of Performance Monitoring Report would report against forecast and be more detailed.

Complaints

114.7 Council queried the theme of verbal and written communications in complaints received. Matthew Hayday (MH) explained that these complaints had arisen from some challenging calls to the contact centre where due to limits of the GPhC’s remit, we had not been able to meet some requests. Other complaints had been made about the outcomes of decisions about concerns where some misunderstanding about the function of a regulator had led to dissatisfaction.

114.8. DR explained that the organisation was committed to developing long term training and improving culture to ensure that each complainant was treated as an individual and where possible these issues were prevented by improvements in process.
Human Resources

114.9. Members asked for more context in this part of the report. DR replied that this was being developed for the new format of the Performance Monitoring Report and accepted that Council required more assurance than was currently provided by the data.

114.10. **Council noted the performance information provided at Appendix 1 of the paper.**

115. **Any other public business**

115.1. Council asked that more feedback be provided to those who had attended stakeholder engagement events on what the organisation had learnt from them. Rachael Oliver (RO) explained that participants do get a report but acknowledged that the gap between the event and the report being distributed could be too long.

115.2. The Chair reminded Council that the judicial review requested by the Pharmacists’ Defence Association (PDA) on the Standards was due to be heard on Thursday 23 March. A report would come to the next Council meeting in April.

115.3. This being their last meeting as Council members, the Chair thanked Sarah Brown and Liz Kay for their very considerable work for the GPhC since, and even before, its establishment. The organisation owed them a great deal for their time and effort, good judgement and knowledge and wished them well for the future.

115.2. There being no further public business, the meeting closed at 11:20am.

**Date of the next meeting:**

Thursday 6 April 2017
Meeting paper

Council on Thursday, 06 April 2017

Public business

Standards for pharmacy professionals: additional consultation

Purpose
To provide Council with a report on the feedback from the consultation relating to the proposed changes to the examples under Standard 1 of the new standards for pharmacy professionals

Recommendations
Council is asked to:

i. Note the analysis of the responses to our consultation (Appendix 1);

ii. Note the analysis of the effects on equality (Appendix 2);

iii. Discuss the themes relating to the revised examples under Standard 1;

iv. Agree the wording of the revised examples under Standard 1;

v. Agree whether the new standards for pharmacy professionals can come into force in May 2017; and

vi. Confirm that any significant change in the law, such as euthanasia or assisted suicide, would necessitate an immediate review of our standards and guidance.

1. Introduction

1.1. Between April and June 2016, we consulted on new standards for pharmacy professionals, which are due to come into effect in May 2017. There are nine standards that every pharmacy professional is accountable for meeting, and these describe how safe and effective care is delivered through ‘person-centred’ professionalism. Each standard is followed by examples of the types of attitudes and behaviours that pharmacy professionals should demonstrate.

1.2. Feedback from the initial standards consultation led us to conclude that the examples we gave under Standard 1 regarding religion, personal values and beliefs were not compatible with person-centred care. So, in October 2016 Council approved the new standards subject to further consultation on examples under Standard 1 as follows:

- Retain the wording “recognise their own values and beliefs but do not impose them on other people”
- Substitute the wording “tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers” for “take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs”

1.3. At the same time, we consulted on new supporting guidance, which is intended to reflect the broad range of situations when a pharmacy professional’s religion, personal values or beliefs might impact on their ability to provide services in certain circumstances and give practical information to help them make sure they make the care of the person their priority.

1.4. This paper discusses the first of two reports analysing the responses to the further consultation on Standard 1 and focuses on comments relating to the revised examples, as well as the anticipated impact of the proposed changes on pharmacy professionals, employers and users of pharmacy services.

1.5. A second report will follow in due course, which will include a more detailed analysis of comments in relation to the supporting guidance.

2. Key considerations

Consultation, analysis and reporting

2.1 The consultation was open for 12 weeks between 13 December 2017 and 7 March 2017. We received 3,450 online responses, as well as 151 postal and email responses from individuals and organisations.

2.2 The consultation attracted more responses from members of the public than GPhC consultations typically have. Whereas by far the largest number of individual responses usually come from pharmacy professionals, in this consultation there were more responses from members of the public.

2.3 The consultation report (Appendix 1) includes:
   - Detailed information about the consultation process, including the policy background, engagement activity and media coverage
   - An explanation about our approach to analysis and reporting
   - A qualitative analysis of the responses from individuals and organisations, including online and postal responses
   - A quantitative analysis of online survey responses from individuals
   - Summaries of the complex issues that we have heard during the consultation, and about the anticipated impact of the proposed changes on pharmacy professionals, employers and users of pharmacy services

2.4 We have considered every response received, as well as notes from stakeholder events and one to one meetings. This has informed the development of our qualitative analysis of themes and issues raised in the consultation. Our thematic approach to analysis allows us to fairly represent the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events.

The overall approach: views, rationales and anticipated impact

2.5 The consultation report includes a detailed summary of the views on our overall approach as well as the complex rationales for supporting or opposing the proposals.

2.6 Broadly speaking, pharmacy professionals were more likely to agree with the proposals than members of the public. There was a noticeable difference in the overall stance taken by these different groups of respondents to this consultation: the proposed approach was supported by the majority of the pharmacy professionals taking part in the consultation, but objected to by the majority of respondents who identified
as members of the public. On the other hand, in our focus groups with members of the public, overwhelmingly the majority agreed with the proposed approach.

2.7 A similarly complex picture emerged in organisational responses, mirroring responses from individuals. Organisations representing the pharmacy sector tended to be in agreement with the proposals, which those whose work is focused on the interests of particular groups presented a more polarised view.

2.8 Unsurprisingly the rationales for supporting or opposing the approach were hugely varied and complex. We have decided not to summarise these in this paper at the risk of omitting key issues or misrepresenting the range of rationales presented to us within the responses. The extensive analysis is included in the appendices.

2.9 In terms of impact, there was a notable difference between how the different groups responded to the online survey, with pharmacy professionals typically viewing the likely impact on different groups as being both negative and positive, and a majority of members of the public viewing the likely impact as a negative. However, members of the public attending our focus groups believed the proposals would have a positive impact on patients, with some negative impacts on pharmacy professionals. Again, the detail of potential impact is included in the analysis.

2.10 Overall, and taking into account general views on the approach, the different rationales, and anticipated impact of the proposals, we do not believe that our fundamental approach to person-centred care is incorrect. Further, we have not identified any new or significant information through the consultation that we believe would require further consideration at this stage.

2.11 We believe that many of the issues raised by respondents – both those who agree and disagree with the approach – could be addressed more effectively through the supporting guidance; and not a change to the examples under Standard 1. This would include expanding and clarifying on key areas such as applying the standards in practice, options for referral, responsibilities of employers, and other related issues.

The legal framework

2.12 Having reflected on feedback from the initial consultation and concluded that the examples were not compatible with person-centred care, we also reviewed the relevant legal framework of equalities and human rights legislation prior to launching our additional consultation.

2.13 The current law in this area is relatively recent, based as it is on the Human Rights Act 1998 (which incorporates into domestic law the rights and liberties enshrined in the European Convention on Human Rights) and the Equality Act 2010, which consolidates multiple pieces of legislation into one single Act. The legislation seeks to protect competing rights fairly, for example the right to manifest religious belief and the rights of others not to be discriminated against. New and emerging case law has also played a vital role in shaping and clarifying our understanding of the interaction between equality and human rights law, and balancing competing rights.

2.14 Our initial review of the legal framework led us to believe that the examples we gave under Standard 1 were too weighted towards accommodating the pharmacy professional’s values and beliefs, as opposed to what the law requires of them as a service-provider. We felt that a more considered approach would better balance the rights of individual pharmacy professionals, and the rights and needs of their colleagues and service users.

2.15 In our view, the revised examples strike the right balance in protecting the religious freedom of pharmacy professionals and preventing discrimination against service users. In essence, the revised approach makes
clear the onus is on pharmacy professionals to ensure that they are not in a position where refusal to provide services would result in a person not receiving the care or advice they need, or breach human rights or equality legislation.

2.16 We have received feedback on the revised examples, which includes comments on a number of legal aspects. Some respondents - both groups and individuals - have argued that the proposals could amount to discrimination against pharmacy professionals or breach their rights under Article 9 of the ECHR, namely the right to freedom of thought, conscience and religion. Conversely, others argue that the new approach is more in line with human rights and equality legislation.

2.17 Indeed, some respondents have argued that the revised standards and guidance should go further to protect the rights of patients seeking pharmacy services. The Professional Standards Authority (PSA) have argued that there are insufficient reasons for pharmacy professionals, as part of the NHS workforce, to withhold legal, NHS-approved treatments from patients, unless their right to do so is set out in legislation. Further, the PSA argue that patients and the wider public expect to receive treatment without delay or hindrance – a principle which is enshrined in the NHS constitution.

2.18 Having considered our own legal analysis and the responses to the consultation, we have not identified anything to indicate that our approach is legally flawed or otherwise incompatible with the current framework of human rights and equality law. We have also reviewed all of the case law highlighted during the consultation process by different respondents. Of the cases not already considered by our legal team previously, we have not identified anything which raises significant concerns about our approach.

2.19 Overall, we remain of the view that the proposals are fair, justified and better reflect person-centred professionalism. Insofar as the proposals might have an adverse effect on people with protected characteristics we consider that it is a proportionate means of achieving a legitimate aim, or aims – and are therefore lawful.

Euthanasia and assisted suicide

2.20 A number of respondents, both individuals and groups, have argued that our proposals could compel pharmacy professionals to be involved in cases of euthanasia or assisted-dying. Council should note that both active euthanasia and assisted suicide are illegal under English law. In England and Wales assisting a suicide is a crime. There is no specific crime of assisting a suicide in Scotland. However, it is possible that helping a person to die could lead to prosecution for culpable homicide.

2.21 It will be for the law-makers to decide on any future change to the law in this area. It would be inappropriate for us to reference or speculate in standards or guidance about the implications of any hypothetical future legal change in this area. However, it is important to confirm that any significant change in the law, euthanasia or assisted suicide being examples, would necessitate an immediate review of our standards and guidance.

3. Equality and diversity implications

3.1 Council has previously considered a full equality impact assessment consistent with our responsibilities as set out in the Equalities Act 2010, as part of the earlier consultation on the standards.

3.2 Equality and diversity has informed this additional consultation from the outset and we conducted a full equality and diversity analysis, which is attached at Appendix 2.
3.3 The analysis includes an overview of the work we have completed to inform our understanding of the equality and diversity dimensions of the proposed changes; to identify any trends or issues that apply to people who share protected characteristics; and, to consider the potential impact on this range of equality groups.

3.4 Our equality work has also been informed by our quantitative and qualitative analysis of responses to the consultation; the available data and/or evidence relating to groups by reference to protected characteristics; and, our extensive engagement with a wide variety of stakeholders.

4. Communications

4.1 The new standards for pharmacy professionals are due to come into force in May 2017. Our communications and engagement activities to launch and implement the new standards are already underway. This includes a particular focus on digital channels and tools, such as an app, to promote the standards and enable registrants to access the standards and guidance on their electronic devices.

4.2 If Council is minded to approve the examples under Standard 1 we will produce additional communications materials, including a set of FAQs, to further summarise what the changes mean, and address some of the misconceptions raised throughout the process, prior to the launch of the full supporting guidance.

5. Resource implications

5.1 The resource implications for this work, including communication and implementation of the new standards, have been accounted for in existing budgets.

6. Risk implications

6.1 The standards underpin our regulatory work and it is important that they reflect Council’s commitment to promoting a culture of professionalism and the delivery of compassionate person-centred care.

6.2 Confidence in the standards could be undermined if full consideration is not given to the responses and views we have heard. It is also important that we are able to communicate clearly why Council has made its decisions, as this will assist in communicating and explaining any changes to the standards.

6.3 It is also vital that the standards reflect our understanding of the relevant law and that this is supported by our own legal analysis and external opinion.

7. Monitoring and review

7.1 The standards will be kept under continuous review, with a full review carried out every 3-5 years.

7.2 The supporting guidance, once approved, will be reviewed as and when appropriate.

Recommendations
Council is asked to:

i. Note the analysis of the responses to our consultation (Appendix 1);

ii. Note the analysis of the effects on equality (Appendix 2);

iii. Discuss the themes relating to the revised examples under Standard 1;
iv. Agree the wording of the revised examples under Standard 1;
v. Agree whether the new standards for pharmacy professionals can come into force in May 2017; and
vi. Confirm that any significant change in the law, such as euthanasia or assisted suicide, would necessitate an immediate review of our standards and guidance.

Laura McClintock, Head of Policy and Standards
General Pharmaceutical Council
Laura.McClintock@pharmacyregulation.org
Tel 020 3713 8079

Andy Jaeger, Head of Data and Insight
General Pharmaceutical Council
Andy.Jaeger@pharmacyregulation.org
020 3713 7960

27 March 2017
Consultation on religion, personal values and beliefs

First report of the consultation

1. This is the first of two reports analysing responses to our consultation on religion, personal values and beliefs. It focuses primarily on issues related to standard 1 of the new standards for pharmacy professionals, in relation to person-centred care, and the anticipated impact of that change on pharmacy professionals, employers, and users of pharmacy services. A second report will follow, which will include a more detailed analysis of comments received in relation to the guidance on religion, personal values and beliefs in pharmacy practice.

Policy background

2. Between April and June 2016, we consulted on proposed new standards for pharmacy professionals, which are due to come into force later this year. These nine standards, for which every pharmacy professional is accountable, describe how safe and effective care is delivered through person-centred professionalism.

3. Standard 1 states that pharmacy professionals must provide person-centred care. In the context of religion, personal values and beliefs, the examples of how to apply this standard in practice included the requirement for pharmacy professionals to tell employers or others if their values or beliefs prevent them from providing care, and that they should refer people to other providers of pharmacy services. Many respondents who commented on this standard told us that pharmacy professionals should not be able to refuse to provide services based on their personal beliefs, arguing that this contradicts the principle of person centred care.

4. The new standards for pharmacy professionals were approved in October 2016, subject to further consultation on changes to the examples under the standard 1 which relate to religion, personal values and beliefs. These changes would mean that pharmacy professionals will be required to take responsibility for ensuring that person-centred care is not compromised by their religion, personal values or beliefs. We believe this is compatible with our policy of person-centred care, and better reflects equalities and human rights legislation.

5. If approved, the proposals will change the expectations placed on pharmacy professionals when their religion, personal values and beliefs might impact on their ability to provide certain services, and shift the balance in favour of the needs and rights of the person in their care. While a referral to another service provider may still be appropriate, this will depend on how the referral is carried out, and the pharmacy professional must take responsibility for the continuity and/or outcome of the person’s care.

6. Alongside this change in the standards, we also consulted on new supporting guidance. This is intended to help pharmacy professionals apply the standard in practice and reflect the broad range of situations when a pharmacy professional’s religion, personal values or beliefs might impact on their ability to provide services.
About the consultation

7. The consultation was open for twelve weeks, beginning on 13 December 2016 and ending on 7 March 2017. To ensure we heard from as many individuals and organisations as possible:

- An online survey was available for individuals and organisations to complete during the consultation period, and we also received a small number of postal and email responses
- We organised a series of stakeholder events aimed at pharmacy professionals, pharmacy service users and other interested parties
- We also offered one to one meetings with a wide range of organisations that might have a potential interest in the subject matter of the consultation, the majority of whom agreed to meeting with us, and then subsequently submitted responses to the consultation.
- We also created a toolkit of materials for these organisations to disseminate information about the consultation to their members, including a press release and a presentation.
- We promoted the consultation with registrants through our online publication Regulate and also promoted it with national and trade media.

Online survey

8. The online survey asked questions about:

- the proposed change to the standard
- revised guidance on religion, personal values and beliefs in practice
- the impact of these changes on pharmacy professionals, employers and pharmacy services users.

9. We also collected information about respondents’ interest in the consultation, and their protected characteristics.

10. 3,450 online responses were received from individuals and members of the public at the point the consultation closed. Alongside these, we also received 151 postal and email responses from individuals and organisations, some using the consultation document, and others writing more generally about their views.

Stakeholder events

11. The questions in the online survey were also used as a structure for discussion in our stakeholder events:

- We held pharmacy sector focus groups in England, Scotland and Wales, and a roundtable meeting in London, attracting a mix of pharmacists, pharmacy technicians, people working in education and training, employers, pre-registration pharmacists, and representatives from professional bodies and trade bodies
- We organised three patient focus groups, in England, Scotland and Wales
- We also held a discussion with an older people’s group, and met with trainees and assessors at Preston College.
12. The questions in the online survey were also used to structure discussions in our stakeholder events, allowing us to capture people’s views, and include them in our consultation analysis. These events also used case studies to stimulate discussion on different applications for the standards and guidance in practice.

13. Around 200 individuals and representatives of organisations attended these events.

**One to one meetings**

14. We invited a wide range of organisations that might have an interest in the consultation to engage with us directly, so that we could hear their views on the proposals, and discuss in detail the impact on pharmacy professionals, employers and members of the public.

15. As with the stakeholder events, notes from these meetings were captured in a way that allowed them to be included in our analysis of consultation responses. A number of these organisations also submitted postal responses to the consultation, or completed the online survey.

16. We held one to one meetings with 29 organisations during the consultation period.

**Media coverage**

17. We promoted the consultation through press releases and social media activity, resulting in considerable media coverage during the period of the consultation.

18. December saw limited media cover, with the pharmacy publications P3 and the Pharmaceutical Journal covering the launch, including comment from the groups Christians in Pharmacy and the Muslim Doctors Association.

19. In January there was further coverage in the Pharmaceutical Journal and C+D during this month and into early February in response to initiatives from the National Secular Society and the Christian Institute amongst others.

20. Around mid-February, the consultation began to receive attention outside the pharmacy press, with blog posts on Conservative Home, Anglican Mainstream and Christian Medical Fellowship websites, the publication of an article and video by the Christian Institute, and a further press release from the National Secular Society. An article was published in The Tablet, one of the UK’s most prominent Catholic newspapers, and there was also coverage on two American websites, Life News and National Right to Life News Today. Finally, as the consultation was drawing to a close in March, an article was published in the Catholic Herald.

**Petition**

21. On 1 March, a petition against the proposed changes was launched on the website CitizenGO, a campaigning website focusing action on issues related to right to life and religious liberty. 7,782 individuals signed the petition.
Our overall approach to analysis and reporting

22. We have considered every response received, as well as notes from stakeholder events and one to one meetings. Every response received during the period of the consultation has been considered in the development of our qualitative analysis of themes and issues raised in the consultation. Our thematic approach allows us to represent fairly the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events. We have treated the CitizenGO petition as an organisational response.

23. The variety of routes for individuals and organisations to respond to the consultation means that some duplication is inevitable. For example, some organisations have met with us in one to one meetings, and have also submitted online and postal responses, as well as mobilising individual members to respond to us directly. Again, to ensure we deal with this fairly, we have treated each kind of response in the same way, and focused on the issues that have been raised.

24. Our qualitative analysis can be found in section A of this report, beginning on page 5.

25. Our quantitative analysis of online survey responses from individuals can be found in section B, beginning on page 11.

26. For transparency, we have provided a full list of the organisations that have engaged in the consultation at the end of this report, in section C, on page 21.
A: Qualitative analysis of consultation responses

27. This section presents a qualitative analysis of responses from individuals and organisations, including online responses from individuals and organisations, as well as postal responses from these groups, notes of engagement events, and notes of meetings with organisations. It should be read in conjunction with the quantitative analysis of the consultation.

28. The report provides summaries of the issues we heard about during the consultation. The focus of this report is particularly on the questions about the proposed changes to the standards and impact on different groups. A second report will focus on the questions around guidance to support registrants in how to meet the standard.

29. An important part of this consultation was a ‘self-selection’ survey; anyone with an interest in the consultation could respond. As with any consultation, we expect that individuals and groups who view themselves as being particularly affected by the proposals, or who have strong views on the subject matter, are more likely to have responded. Responses cannot therefore be viewed as representative of a larger population, in the way that a probability sample could be. Even where our analysis is broken down into subsets, views are not necessarily representative of wider groups, such as members of the public or pharmacy professionals. To help us understand the nature of the individuals who have responded to this consultation, we have also therefore analysed some of the data on protected characteristics that was collected as part of the consultation. This can be found in section B, and helps to illuminate our qualitative findings.

Our approach to qualitative analysis

30. A coding framework was developed to identify different issues and topics coming up in responses, to identify patterns as well as the prevalence of ideas, and to help structure our analysis. The framework was built bottom up through an iterative process of identifying what emerged from the data, rather than projecting a framework set prior to the analysis on the data.

31. Open questions were analysed using this coding framework. The qualitative nature of the responses here meant that we were presented with a variety of views, and rationales for those views. Responses were carefully considered and coded through the iterative analysis process. The coding frame was used to analyse both responses to the formal consultation survey, as well as notes from meetings and events, and other responses that we received.

32. Our quantitative analysis in section B focuses only on responses from individuals; combining responses from individuals and from organisations (that may represent large numbers of individuals) would create an inaccurate weighting. In this section of the report however, where our focus is on the themes and issues arising from consultation responses, we have considered views from individuals and organisations alongside each other. In our reporting, we distinguished between individual and organisational responses, where it is meaningful to do so.
33. While the quantitative analysis in section B provides a steer to the overall understanding of individual responses, it needs to be read together with this analysis to yield more nuanced, richer views. The combination of both qualitative and quantitative responses allows for a holistic understanding of the issues around and the impact of the proposals.
What we heard: views on the overall proposal

34. This consultation attracted more responses from members of the public than GPhC consultations typically have. Whereas by far the largest number of individual responses usually come from pharmacy professionals, in this consultation there were more responses from members of the public.

35. The mix of organisations engaging with this consultation was also more varied than typical: we heard from a number of organisations representing different faith groups, or those with secular views, as well as from organisations representing patients and service users in general as well as those with specific protected characteristics. In addition we heard from a number of organisations representing all parts of the pharmacy sector. A list of organisations that engaged in the consultation can be found in section C.

36. The first part of the consultation gauged the extent to which the GPhC’s new approach was supported by respondents, and elicited their views on the proposals. Broadly speaking, pharmacy professionals were more likely to agree with the proposals than members of the public. There was a noticeable difference in the overall stance taken by these different groups of respondents to this consultation: the proposed approach was supported by the majority of the pharmacy professionals taking part in the consultation, but objected to by the majority of respondents who identified as members of the public.

37. Analysis of the open questions provides an opportunity to explain and explore these views in more detail. Although there were strong patterns in the responses, it also needs to be recognised that a variety of reasons were given for either agreeing and or not agreeing with the proposed approach. This section seeks to give a summary of the different views heard.

38. Many respondents, both individuals and organisations, saw the proposal as a positive step in further strengthening person-centred care in pharmacy, recognising the positive impact this would have on different groups of service users, by giving them more consistent access to services. In their examples, they referred to a wide range of services, including emergency hormonal contraception. In contrast, a large proportion of the members of the public focused solely on emergency hormonal contraception, overwhelmingly raising this as problematic in the context of the proposed change.

39. On the other hand, in our focus groups with members of the public, overwhelmingly the majority agreed with the proposed approach. Many participants thought the revised example under standard 1 was clear and reflected what was expected of pharmacy professionals by the public. Many also felt that the approach better reflected person-centred care, and that it would help to promote consistent and non-judgmental services for the public. Others commented that the revised approach reflects what they would currently expect from their pharmacy professionals.

40. A similarly complex picture emerged in organisational responses, mirroring responses from individuals. Organisations representing the pharmacy sector tended to be in agreement with the proposals, which those whose work is focused on the interests of particular groups presented a more polarised view.

41. There were some mixed views from participants in our events about how they interpreted the revised example, specifically about whether referral to another pharmacy service provider was still an option, as this word had been removed from the example set out under the standards. While many survey respondents felt the standard and guidance were clear, similarly there were those who were concerned that the wording was ambiguous and too much was left open for interpretation. Indeed there were those, both in support as well as opposition of the overall proposal, who thought the new approach would not
allow for referral and would force professionals to provide any services, even those that would go against their conscience.

42. Some participants in our events felt it was clear that there are many ways for pharmacy professionals to demonstrate that they are taking responsibility to ensure care is not compromised, including making referrals to other providers in appropriate cases. However, other participants interpreted the example to mean that pharmacy professionals would always be required to provide services which they may object to because of their religion, personal values or belief, if the services are legal and safe for the person.

Rationales for supporting the proposals

43. Of the individual respondents who broadly supported the proposal, many simply expressed that the needs of pharmacy service users should always come first and that pharmacy professionals should not impose their personal values or beliefs on those using services. Some respondents commended the proposals for the emphasising the active role a professional should take in ensuring the continuity of care, many mentioning that it was “about time” this change was happening.

44. There were also those who felt the proposal didn’t go far enough and that professionals should never refuse service because of personal and religious beliefs, particularly where such services were part of NHS provision. It was emphasised that patients should have a right to any legal, clinically appropriate service.

45. Overall, many of those supporting saw the approach as strengthening current practice and giving further clarification on the responsibilities of professionals. They also saw this as a positive step for service users who would benefit from improved, more consistent access to services and better quality, non-judgmental care.

46. There were also respondents who supported the proposal and who in their open response identified as having religious beliefs, yet emphasised that as health professionals the needs of the person seeking care would always be their primary focus. Others noted that religious beliefs are often important in positively informing a practitioner’s professional ethics, and it is not desirable to separate these two as long as the outward manifestations of personal values and beliefs are not imposed on those receiving care.

47. Some professionals noted that personal values and beliefs can have a positive impact on practice and care, however they felt the tone of the consultation document and the draft guidance unnecessarily problematized religion. It was said the tone could be more balanced recognising the positive impact of strong personal values and beliefs can have on healthcare practice.

48. Broadly, the organisations that supported the proposals were pharmacy organisations, explicitly secular organisations, and organisations representing different groups of health service users, as well as some faith based organisations. In their responses, many recognised the difficulties in this area and raised important points for further consideration, which will be more fully addressed in the context of producing guidance to support the implementation of the standard. On the whole, these organisations welcomed the strengthened focus on person-centred care and the active role professionals would play in ensuring care is not compromised. At the same time there was recognition that balancing the rights of both service users and professionals is not easy. Many respondents also asked further clarification on the implementation of the new standards, for example in the context of existing employment or possible fitness to practise implications.
Both individuals and organisations made references to the employment law and how the proposed approach would align with this. There were also those who commended the approach proposed for restating equality, non-discrimination and human rights principles as key to effective person-centred care.

**Rationales for opposing the proposals**

50. It is important to note that opposition or support was not always related to whether or not respondents identified themselves as having religious beliefs. Some saw the proposal simply as a further erosion of professional autonomy and decision-making, without necessarily making reference to religious beliefs, and objected to proposal on this basis.

51. Those who opposed the proposals stated that pharmacy professionals should not be put in a position where their values and personal beliefs are compromised. There were many in this group of respondents who took the proposal as saying that a pharmacy professional would have to personally provide all services and that referral was never an option. Many of these answers raised concerns, explicitly or implicitly, that the regulator is effectively forcing pharmacy professionals to provide services that go against their personal values and beliefs. Many respondents also said that neither the regulator nor patients should impose their values on professionals. Some respondents wanted the values and beliefs of both pharmacy service users and pharmacy professionals to be balanced, so that neither group would be disadvantaged.

52. There were also some who felt that taking part in any way in provision of services that went against a professional’s personal beliefs, whether this was by referring or in any other way, would not be right. Concerns were raised that the new approach would infringe on professionals’ rights, causing some to leave the profession and increasing the likelihood of pharmacy professionals, particularly those with religious beliefs, being discriminated against by employers.

53. There were also some, who were concerned that the approach would enable pharmacy service users to demand any services they want, rather than services being provided based on clinical need.

54. Finally, there were many who considered emergency hormonal contraception as being an abortifacient, and who consequently thought that supplying it, or even making a referral to another pharmacy professional, would constitute taking part in an abortion; they objected to the proposed approach on this basis.

55. Organisations opposed to the new approach based their stance on the interpretation that the new proposal would require pharmacy professionals to supply medicines or services even when this was against their conscience. Many of these responses challenged whether the approach would be in line with equalities legislation, or in breach of article 9 of the European Convention of Human Rights. Some respondents felt the new approach could benefit employers and could open the door for discrimination against employees.

56. Some organisations who did not agree with the new approach said they were however in support of person-centred care. They raised concerns that pharmacy services users would be enabled to choose any medication that they felt fit, rather than this being a decision by the professional.
57. A further problematic area that was particularly of concern to those who were opposed to the proposed approach was the role of pharmacy professionals in assisted dying should the law in this area change in future.

58. Finally, it was commented that the overall tone of the document seemed to problematize the public practice of religion, personal values and beliefs, almost as if to say these do not have a place in healthcare. Furthermore, some respondents noted the lack of reference to ‘conscience’ and ‘conscientious objection’ in the standards and guidance. Several comments were made in reference to the approach by the General Medical Council which they perceived as better.

What we heard: impact of the new approach on pharmacy professionals, employers and pharmacy service users

59. The second part of the consultation survey focused on the possible impact of the new approach on three groups: pharmacy professionals, employers and people using pharmacy services.

60. Again there was a notable difference between how the different groups responded to the online survey, with pharmacy professionals typically viewing the likely impact on different groups as being both negative and positive, and a majority of members of the public viewing the likely impact as a negative.

Impact on pharmacy professionals

61. In the comments on the impact on professionals, it was frequently mentioned that some pharmacy professionals might leave the profession as a result of the proposed changes. This was raised by both those who supported the proposal and those who did not, and seen as both a positive and a negative outcome. Some concerns were raised about the diversity of the workforce and how this could decrease as a result.

62. And yet, some professionals also felt the proposed approach would bring much needed clarity: professionals would know where they stand, and prospective students would know what is expected of them on entering the pharmacy workforce.

63. On the other hand, some respondents, whether they supported or opposed the approach, thought the new approach could also have negative impact on professionals navigating a new situation. Those opposed to the plans felt this would infringe on the rights of those who feel unable to provide certain services because of religious beliefs, indeed this was at times seen as infringing on those individuals’ rights. It was feared that this could have an impact on employment opportunities. Furthermore some felt that the pressure to act against own values and beliefs was likely to give rise to stress, anxiety and overall have mental health implications on some professionals.

64. There were many who felt the changes would merely reinforce current practice, and those who felt there will be no impact on practice at all, suggesting that pharmacy professionals would simply carry on as they have done to date.

65. A small group opposed to the proposals not on religious grounds but because they felt the new approach would erode professional autonomy and professionals’ ability to exercise their own professional judgment.
66. While some respondents recognised this could be a problematic change for some professionals, it was felt that on the whole the change would be beneficial to pharmacy service users, whose care should be the first priority and this approach would further strengthen this.

**Impact on employers**

67. On the positive side, it was felt the proposal would bring clarity and there would be an improvement to both quality of care and services. Continuity of service provision would be improved and there would be less of a risk for services not being available.

68. The implementation of the proposed approach raised questions, and this was an area where many respondents wanted further clarity: how would the proposals be implemented in practice, how would employers balance the new requirements with employment law, how would they manage any situation with current employees, and would there be fitness to practice implications. Implementation was an area where further guidance would be needed.

69. Those who strongly opposed to the proposals on religious grounds pointed out that there were likely to be employers who would feel they had to go against their personal values and beliefs.

**Impact on pharmacy service users**

70. Overwhelmingly those who supported the GPhC’s proposal felt that it would benefit people using pharmacy services by enshrining their needs as a priority, ensuring that access to care would not be compromised, and that the availability of services would be more consistent. Several respondents mentioned that service users would be able to seek services without being made to feel they were judged, and that they would also be able to access services in a timely manner, which can be critical for the efficacy of certain medicines.

71. However a very different picture emerged in the responses of those who opposed to the proposals. It was felt that the quality of services and care would deteriorate as professionals would have to act against their beliefs or leave the profession altogether. Further, many commented that service users with religious beliefs would not be able to seek advice from a professional with similar beliefs.

72. In our patient focus groups, many participants talked about examples of the types of barriers that a person might face when trying to access services and some people gave personal examples. Most participants agreed that it would be important for pharmacy professionals to consider these types of issues or barriers when providing person-centred care. The majority of participants raised privacy and confidentiality as important issues, feeling that the new approach would give assurance to pharmacy services users that they would be treated with dignity and respect.

73. Participants across the different groups also recognised that this is a difficult and complex area for pharmacy professionals. However, many felt that potential difficulties could be managed by pharmacy professionals having open and honest conversations with their employers and making advance arrangements for service provision.

74. Across all groups, participants felt it was important that students, or people considering a career in pharmacy, are informed about the standards expected of pharmacy professionals at an early stage.
B: Analysis of individual online survey responses

75. This section presents a quantitative analysis of online survey responses from individuals. 3,450 online responses were received at the point the consultation closed on 7 March 2017. In preparing this analysis, decisions to include and exclude a small number of responses were made for reasons set out below:

- Organisational responses are treated separately in the qualitative analysis. This is to take account of those organisations that are representative bodies, to ensure that their views are given appropriate weight, compared to those of an individual respondent.

- A small number of respondents (less than 10) who had indicated they were responding on behalf of an organisation were reclassified as individual respondents, and are included in this analysis. Half of these had chosen to respond anonymously, while other respondents identified themselves as members of organisations that had sent an official postal response to the consultation.

- A slightly larger number (less than 40) of multiple responses were received from the same individuals. These were identified by matching on email address and name. In these cases, the individual respondent’s most recent response was included in the analysis.

76. In total, 3,361 individual online responses are included in this analysis.

Survey structure

77. The survey contained a mixture of quantitative questions: binary questions, for example, “do you agree with these changes?”; questions with scales, for example, “will the impact be...”; and multiple choice questions, for example, “where do you live?”. There were also a number of open ended questions.

78. Every response to an open ended question (including those included and excluded as above) has been read, analysed, considered and coded in the preparation of the qualitative analysis, in section A.

79. This report sets out a summary of individual online responses to the quantitative questions only.
Exploring differences between groups

80. This analysis highlights differences between two pairs of subsets of respondents: members of the public and pharmacy professionals; and respondents with religious beliefs and with no religious beliefs. The rationale for presenting results for these subsets, and the methodology for creating these groups, is set out below.

81. Although these subsets are included in the report, it is important to underline that these results cannot be taken as representative of others who share the same characteristics. Respondents to the consultation are particularly motivated to respond, and overall the results are subject to self-selection bias. The subsets do however illustrate the variety of views between and within each of these groups, and underline that those who share characteristics, for example having a religious belief, will not necessarily share the same opinions.

Members of the public and pharmacy professionals

82. Unusually for a GPhC consultation, a very large number of responses were received from members of the public (n=1,780), with more responses from these individuals than from pharmacy professionals (n=1,372). Given that the proposals on religion, personal values and beliefs would affect pharmacy professionals and members of the public differently, the responses of these groups are set out as subsets of the whole. Other groups, such as pre-registration trainees, had small numbers of respondents overall and are not presented separately.

Respondents with religious beliefs and no religious beliefs

83. The survey also asked respondents a series of questions about their protected characteristics, as defined in the Equality Act 2010. Given the relevance of the proposals to religion, two further subsets of respondents have been identified: those who indicated that they have religious beliefs (n=2,049) and those who do not (n=772).

84. The subset of respondents with religious beliefs includes all those individuals who selected one of the six religious groups identified in the survey: Buddhist, Christian, Jewish, Hindu, Muslim or Sikh.

85. The subset of respondents with no religious beliefs includes all those individuals who selected None.

86. Those who selected Other, and who completed a free text responses, fall into three groups:
   - Individuals whose responses could be allocated to an existing category, for example Church of England, Roman Catholic, or Pentecostal, have been included for analytical purposes as part of a larger group, for example Christian, and have been included in the subset of respondents with religious beliefs.
   - Individuals who identified themselves as members of religious groups not identified in the survey, for example Jain or Pagan, and have been included in the subset of respondents with religious beliefs.
   - Individuals who identified themselves as affiliated with non-religious belief systems, such as Atheist and Humanist, have been included in the category None, and the subset of respondents with no religious beliefs.

87. Respondents who selected Prefer not to say, or who skipped the question, have not been presented separately.
How the pairs of subsets relate to each other

88. Among members of the public, 1,006 (56.5%) are included in the subset of those with religious beliefs, and 451 (25.3%) in the subset of those with no religious beliefs. Among pharmacy professionals, 923 (67.3%) have religious beliefs, and 292 (21.3%) have no religious beliefs.

Detailed analysis

89. The tables below present the number of respondents selecting different answers in response to questions in the online survey. The ordering of relevant questions in the survey has been followed in the analysis.

90. Because of the sensitive nature of some of these questions, cells with fewer than 10 respondents have been expressed as <10. Consequently, the tables are presented without totals or percentages, so that small numbers cannot be identified by calculation. Skipped answers have not been included. Cells with no data are marked with a dash.

91. Where there are notable differences in responses between subsets, these have been described in the supporting narrative.

About respondents

92. A series of introductory questions sought information on individuals’ general location, and in what capacity they were responding to the survey.

93. For pharmacy professionals, further questions were asked to identify whether they are pharmacists, pharmacy technicians or pharmacy owners, and where they usually work.

<table>
<thead>
<tr>
<th>Where do you live?</th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2705</td>
<td>1454</td>
<td>1130</td>
<td>1649</td>
<td>630</td>
</tr>
<tr>
<td>Scotland</td>
<td>321</td>
<td>161</td>
<td>136</td>
<td>209</td>
<td>66</td>
</tr>
<tr>
<td>Wales</td>
<td>163</td>
<td>94</td>
<td>62</td>
<td>99</td>
<td>45</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>40</td>
<td>19</td>
<td>&lt;10</td>
<td>28</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Other</td>
<td>80</td>
<td>39</td>
<td>30</td>
<td>48</td>
<td>19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you responding as</th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>A member of the public</td>
<td>1780</td>
<td>1780</td>
<td>-</td>
<td>1006</td>
<td>451</td>
</tr>
<tr>
<td>A pharmacy professional</td>
<td>1372</td>
<td>-</td>
<td>1372</td>
<td>923</td>
<td>292</td>
</tr>
</tbody>
</table>
A pre-registration trainee | 32 | - | - | 21 | <10
A student | 67 | - | - | 45 | <10
Other | 49 | - | - | 20 | <10
Other healthcare professional | 55 | - | - | 31 | 11
Other student | <10 | - | - | <10 | <10

### Pharmacy professionals: part of the register

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>1127</td>
<td>-</td>
<td>1127</td>
<td>761</td>
<td>226</td>
</tr>
<tr>
<td>Pharmacy technician</td>
<td>195</td>
<td>-</td>
<td>195</td>
<td>126</td>
<td>58</td>
</tr>
<tr>
<td>Pharmacy owner</td>
<td>30</td>
<td>-</td>
<td>30</td>
<td>20</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

### Pharmacy professionals: usual workplace

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community pharmacy</td>
<td>780</td>
<td>-</td>
<td>780</td>
<td>544</td>
<td>147</td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>307</td>
<td>-</td>
<td>307</td>
<td>194</td>
<td>81</td>
</tr>
<tr>
<td>Pharmaceutical industry</td>
<td>37</td>
<td>-</td>
<td>37</td>
<td>27</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Pharmacy education and training</td>
<td>55</td>
<td>-</td>
<td>55</td>
<td>35</td>
<td>12</td>
</tr>
<tr>
<td>Primary care organisation</td>
<td>98</td>
<td>-</td>
<td>98</td>
<td>69</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>77</td>
<td>-</td>
<td>77</td>
<td>39</td>
<td>23</td>
</tr>
</tbody>
</table>

94. The distribution of individual respondents across England, Scotland and Wales is broadly similar to the distribution of the UK population, and there are no notable differences between the subsets of members of the public, pharmacy professionals, those with religious beliefs and those with no religious beliefs.

95. In terms of types of respondents, the largest group identified themselves as members of the public (53%) followed by pharmacy professionals (40.8%). Further characteristics and differences between these groups can be found in the final section of this analysis.

96. Among pharmacy professionals, the number identifying themselves as pharmacy owners is notably small (2.2%). However, this group had two potential routes to respond to this consultation: as individuals, and on behalf of organisations. Responses from organisations have been dealt with separately.

97. Just over half of pharmacy professionals responding to the survey (57.6%) identified community pharmacy as their usual workplace. 22.7% of respondents work in hospital pharmacy, with the remainder in other locations.
Consultation questions

98. The core questions in the survey focused on respondents’ views of the proposals in the consultation. Responses were sought on questions relating to agreement with the standards, and the adequacy of the proposed guidance.

99. Questions were also asked about the expected impact of the proposed changes, and what the nature of that impact would be, on a five-point Likert scale from mostly positive to mostly negative. These questions focused on impact on three different groups: pharmacy professionals, employers and users of pharmacy services.

Q1: Do you agree with the proposed changes?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1520</td>
<td>505</td>
<td>952</td>
<td>691</td>
<td>733</td>
</tr>
<tr>
<td>No</td>
<td>1811</td>
<td>1269</td>
<td>414</td>
<td>1352</td>
<td>38</td>
</tr>
</tbody>
</table>

100. Overall, 45.6% of respondents agreed with the proposed changes.

101. There are notable differences between subsets. Among the public, 28.5% agreed with the proposed changes, compared to 69.7% of pharmacy professionals. 33.8% of respondents with religious beliefs agreed, compared to 95.1% of respondents with no religious beliefs.

Q2: Does the revised guidance adequately reflect the broad range of situations that pharmacy professionals may find themselves in?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1716</td>
<td>653</td>
<td>987</td>
<td>897</td>
<td>680</td>
</tr>
<tr>
<td>No</td>
<td>1335</td>
<td>871</td>
<td>357</td>
<td>959</td>
<td>77</td>
</tr>
</tbody>
</table>

102. 56.2% of respondents agreed that the revised guidance adequately reflected the broad range of situations that pharmacy professionals might find themselves in. Among members of the public, the level of agreement decreases to 42.8%, whereas it rises to 73.4% among pharmacy professionals. Between those with religious beliefs and those with no religious beliefs, this difference is more marked, with 48.3% of those with religious beliefs agreeing, compared to 89.8% of those with no religious beliefs.

Q4: Will our proposed approach to the standards and guidance have an impact on pharmacy professionals?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3025</td>
<td>1653</td>
<td>1201</td>
<td>1885</td>
<td>676</td>
</tr>
</tbody>
</table>
Q5: Will the impact [on pharmacy professionals] be

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly positive</td>
<td>906</td>
<td>374</td>
<td>501</td>
<td>359</td>
<td>501</td>
</tr>
<tr>
<td>Partly positive</td>
<td>131</td>
<td>32</td>
<td>92</td>
<td>73</td>
<td>52</td>
</tr>
<tr>
<td>Positive and negative</td>
<td>492</td>
<td>121</td>
<td>347</td>
<td>307</td>
<td>137</td>
</tr>
<tr>
<td>Partly negative</td>
<td>366</td>
<td>214</td>
<td>129</td>
<td>278</td>
<td>24</td>
</tr>
<tr>
<td>Mostly negative</td>
<td>1321</td>
<td>955</td>
<td>268</td>
<td>986</td>
<td>20</td>
</tr>
</tbody>
</table>

103. Overall, 93.2% of respondents noted that the proposals would have an impact of pharmacy professionals, with little notable variation between the subsets. There were however marked differences in how different groups assessed the nature of that impact. Among pharmacy professionals themselves, 44.4% thought the impact would be mostly or partly positive, with 29.6% assessing the impact as mostly or partly negative; members of the public believed the impact on pharmacy professionals would be substantially more negative, with 68.9% assessing the impact as mostly or partly negative. Comparing respondents based on religion reveals 63.1% with religious beliefs believe the impact on pharmacy professionals would be mostly or partly negative, compared to 75.3% of those with no religious beliefs considering the impact to be mostly or partly positive.

Q6: Will our proposed approach to the standards and guidance have an impact on employers?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2685</td>
<td>1470</td>
<td>1059</td>
<td>1673</td>
<td>607</td>
</tr>
<tr>
<td>No</td>
<td>418</td>
<td>108</td>
<td>287</td>
<td>235</td>
<td>132</td>
</tr>
</tbody>
</table>

Q7: Will the impact [on employers] be

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly positive</td>
<td>813</td>
<td>336</td>
<td>450</td>
<td>322</td>
<td>447</td>
</tr>
<tr>
<td>Partly positive</td>
<td>180</td>
<td>35</td>
<td>139</td>
<td>108</td>
<td>53</td>
</tr>
<tr>
<td>Positive and negative</td>
<td>590</td>
<td>171</td>
<td>383</td>
<td>372</td>
<td>156</td>
</tr>
<tr>
<td>Partly negative</td>
<td>346</td>
<td>219</td>
<td>104</td>
<td>266</td>
<td>18</td>
</tr>
<tr>
<td>Mostly negative</td>
<td>1029</td>
<td>770</td>
<td>184</td>
<td>764</td>
<td>14</td>
</tr>
</tbody>
</table>
In considering impact on employers, the most marked differences are between the views of the public and pharmacy professionals. 78.8% of pharmacy professionals believed there would be an impact on employers, compared to 93.2% of the public. The nature of this impact was also assessed differently: members of the public and those with religious beliefs largely believed the impacts to be mostly or partly negative (64.6% and 56.2% respectively) while those with no religious beliefs believed the impacts would be mostly or partly positive (72.7%). Views among pharmacy professionals were more mixed. 46.7% believed the impact would be mostly or partly positive, with a substantial proportion (30.4%) rating the impact as positive and negative.

Q8: Will our proposed approach to the standards and guidance have an impact on people using pharmacy services?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2698</td>
<td>1435</td>
<td>1115</td>
<td>1608</td>
<td>707</td>
</tr>
<tr>
<td>No</td>
<td>476</td>
<td>211</td>
<td>232</td>
<td>342</td>
<td>46</td>
</tr>
</tbody>
</table>

Q9: Will the impact [on people using pharmacy services] be

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly positive</td>
<td>1259</td>
<td>477</td>
<td>742</td>
<td>530</td>
<td>659</td>
</tr>
<tr>
<td>Partly positive</td>
<td>146</td>
<td>37</td>
<td>102</td>
<td>103</td>
<td>30</td>
</tr>
<tr>
<td>Positive and negative</td>
<td>528</td>
<td>219</td>
<td>262</td>
<td>402</td>
<td>35</td>
</tr>
<tr>
<td>Partly negative</td>
<td>260</td>
<td>178</td>
<td>61</td>
<td>200</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Mostly negative</td>
<td>797</td>
<td>633</td>
<td>109</td>
<td>586</td>
<td>11</td>
</tr>
</tbody>
</table>

Overall, 85.0% of respondents thought the proposals would have an impact on people using pharmacy services, with little variation between the four subsets.

Among members of the public themselves views of the nature of the impact were particularly polarised, with 33.3% respectively assessing the impact as mostly or partly positive, and 52.5% viewing it as mostly or partly negative.

Further analysis of public responses was undertaken to explore the views of those groups that might positively benefit from the proposals, as identified in the equality impact analysis. Although the number of respondents is small, it is notable that 39.6% of women aged 20-39, 44.1% of those with a disability, and 66.7% of LGBT respondents considered the impact of the changes would be mostly or partly positive, compared to 33.3% of members of the public as a whole.

Among pharmacy professionals, 66.1% assessed the impact on people using pharmacy services as being mostly or partly positive. Among those with religious beliefs, 34.8% viewed the impact as mostly or partly positive.
positive, and 43.2% as mostly or partly negative. Among those with no religious beliefs, the proportion assessing the impact as mostly or partly positive rose to 93.2%.
### Monitoring questions

109. In the final section of the survey, data was collected on respondents’ protected characteristics, as defined within the Equality Act 2010. The GPhC’s equalities monitoring form was used to collect this information, using categories that are aligned with the census, or other good practice (for example on the monitoring of sexual orientation). These questions were asked to help understand the profile of respondents to the consultation, to provide assurance that a broad cross section of the population had been included in the consultation exercise. The responses on religion have also been used to help illuminate differences in responses between with religious beliefs and those with no religious beliefs.

#### What is your sex?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>1484</td>
<td>634</td>
<td>762</td>
<td>1013</td>
<td>329</td>
</tr>
<tr>
<td>Male</td>
<td>1625</td>
<td>981</td>
<td>560</td>
<td>999</td>
<td>429</td>
</tr>
<tr>
<td>Other</td>
<td>30</td>
<td>17</td>
<td>10</td>
<td>11</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

#### What is your sexual orientation?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual</td>
<td>34</td>
<td>18</td>
<td>&lt;10</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Gay man</td>
<td>55</td>
<td>22</td>
<td>28</td>
<td>22</td>
<td>30</td>
</tr>
<tr>
<td>Gay woman/ lesbian</td>
<td>16</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>10</td>
</tr>
<tr>
<td>Heterosexual/straight</td>
<td>2532</td>
<td>1247</td>
<td>1153</td>
<td>1756</td>
<td>643</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>20</td>
<td>&lt;10</td>
<td>16</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>425</td>
<td>277</td>
<td>120</td>
<td>184</td>
<td>45</td>
</tr>
</tbody>
</table>

#### What is your age?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>33</td>
<td>11</td>
<td>&lt;10</td>
<td>25</td>
<td>&lt;10</td>
</tr>
<tr>
<td>20 – 29 years</td>
<td>382</td>
<td>99</td>
<td>211</td>
<td>249</td>
<td>86</td>
</tr>
<tr>
<td>30 – 39 years</td>
<td>575</td>
<td>186</td>
<td>365</td>
<td>360</td>
<td>148</td>
</tr>
<tr>
<td>40 – 49 years</td>
<td>604</td>
<td>249</td>
<td>341</td>
<td>363</td>
<td>180</td>
</tr>
<tr>
<td>50 – 59 years</td>
<td>654</td>
<td>348</td>
<td>281</td>
<td>430</td>
<td>151</td>
</tr>
<tr>
<td>60 + years</td>
<td>845</td>
<td>700</td>
<td>126</td>
<td>586</td>
<td>192</td>
</tr>
</tbody>
</table>
### Do you consider yourself disabled?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>162</td>
<td>124</td>
<td>29</td>
<td>92</td>
<td>54</td>
</tr>
<tr>
<td>No</td>
<td>2751</td>
<td>1353</td>
<td>1244</td>
<td>1841</td>
<td>688</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>198</td>
<td>132</td>
<td>52</td>
<td>79</td>
<td>20</td>
</tr>
</tbody>
</table>

### What is your ethnic group?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>2382</td>
<td>1390</td>
<td>892</td>
<td>1518</td>
<td>700</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>103</td>
<td>15</td>
<td>74</td>
<td>101</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Mixed</td>
<td>68</td>
<td>24</td>
<td>35</td>
<td>54</td>
<td>10</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>254</td>
<td>19</td>
<td>203</td>
<td>223</td>
<td>17</td>
</tr>
<tr>
<td>Chinese or Chinese British</td>
<td>17</td>
<td>&lt;10</td>
<td>11</td>
<td>12</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Arab</td>
<td>18</td>
<td>&lt;10</td>
<td>15</td>
<td>16</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>14</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>246</td>
<td>145</td>
<td>83</td>
<td>77</td>
<td>28</td>
</tr>
</tbody>
</table>

### What is your religion?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Public</th>
<th>Pharmacy</th>
<th>Religion</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhist</td>
<td>19</td>
<td>&lt;10</td>
<td>10</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td>Christian</td>
<td>1737</td>
<td>980</td>
<td>664</td>
<td>1737</td>
<td>-</td>
</tr>
<tr>
<td>Hindu</td>
<td>70</td>
<td>&lt;10</td>
<td>67</td>
<td>70</td>
<td>-</td>
</tr>
<tr>
<td>Jewish</td>
<td>18</td>
<td>&lt;10</td>
<td>15</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Muslim</td>
<td>151</td>
<td>&lt;10</td>
<td>128</td>
<td>151</td>
<td>-</td>
</tr>
<tr>
<td>Sikh</td>
<td>22</td>
<td>&lt;10</td>
<td>20</td>
<td>22</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>&lt;10</td>
<td>19</td>
<td>32</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>772</td>
<td>451</td>
<td>292</td>
<td>-</td>
<td>772</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>318</td>
<td>178</td>
<td>109</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
110. In terms of their protected characteristics, there are few differences in the profiles of those with religious beliefs and those with no religious beliefs, with the obvious exception of religious beliefs themselves.

111. The profile of members of the public and pharmacy professionals who answered these questions was also broadly similar, with a few notable exceptions. Members of the public were more likely to be male (60.1% against 42.0%), more likely to be white (86.6% against 67.5%) and more likely to be Christian (59.9% against 50.2%).

112. However, the most notable difference between these two subsets relates to the age profile of respondents. As with other characteristics, the age profile of pharmacy professionals responding to the survey is broadly similar to the GPhC’s register. The age profile of members of the public strongly tends towards older age groups, with 21.8% of respondents aged 50-59, and 43.9% aged 60 years or older.
C: Organisations

The following organisations engaged in the consultation through one to one meetings, attendance at events, providing evidence for our equality impact assessment, and submitting responses to the consultation.

- Acheason Chemist
- Acorn Chemist
- Affinity - Gospel Churches in Partnership
- Anscombe Bioethics Centre
- Association of Pharmacy Technicians United Kingdom
- Association of Independent Multiples Pharmacies Committee
- Badham Pharmacy Ltd
- Bairds Pharmacy
- Bedfordshire Humanists
- BLM
- Board of Deputies of British Jews
- Boots Pharmacists' Association
- Boots Pharmacy
- British Association of Gender Identity Specialists
- British Humanist Association
- British Pharmaceutical Students' Association
- British Pregnancy Advisory Service
- Buddhist Council of Wales
- Buttercups Training Ltd
- Carters Chemist
- Catholic Bishops Conference of England and Wales
- Catholic Medical Association
- Catholic Nurses Association
- Catholic Parliamentary Office
- Catholic Union of Great Britain
- Celesio UK
Centre for Pharmacy Postgraduate Education, University of Manchester
Charles Russell LLP
Chief Pharmaceutical Officer, Scotland
Christian Action, Research and Education
Christian Institute
Christian Legal Centre
Christian Medical Fellowship
Christian Voice
Christians in Pharmacy
Church of England
CitizenGO
Community Pharmacy Scotland
Community Pharmacy Wales
Croydon Local Pharmaceutical Committee
D K Wood Ltd
Dalton Pharmacy
Evangelical Alliance
Faculty of Sexual and Reproductive Health
Fairmans Pharmacy
Family Education Trust
Family Planning Association
Free Church Council of Wales
Friends, Families and Travellers
General Medical Council
GIRES
Guild of Healthcare Pharmacists
Hampshire and Isle of White Local Pharmaceutical Committee
Healthwatch Islington
Healthwatch Lewisham
Healthwatch Salford
Consultation on religion, personal values and beliefs: first report of the consultation

- Hindu Council UK
- Housley Pharmacy
- Jewish Medical Association
- Kamsons Pharmacy
- Lawyers Christian Fellowship
- LGBT Foundation
- Life
- Lindsay & Gilmour
- Mencap
- Midcounties Co-operative
- Mind
- Morrison’s Pharmacy
- Muslim Council of Britain
- Muslim Pharmacists Association
- National Dignity Council
- National LGB&T Partnership
- National Pharmacy Association
- National Secular Society
- Network for Buddhist Organisations
- NHS Ayrshire and Arran
- NHS Education for Scotland
- NHS England Health and Justice Commissioning
- NHS Lanarkshire
- NHS Wandsworth Clinical Commission Group
- Norchem Healthcare
- PCT Healthcare Ltd
- Peverell Community Church
- Pharmaceutical Services Negotiating Committee
- Pharmacists Defence Association
- Pharmacy Law and Ethics Association
- Pharmacy Schools Council
- Pharmacy Voice
- Preston College
- Professional Standards Authority
- ProPharmace
- Race Equality Foundation
- Redbridge Pensioners Forum
- Right To Life
- Rowlands Pharmacy
- Royal Pharmaceutical Society
- School of Pharmacy, Keele University
- Scottish Catholic Medical Association
- Scottish Council of Human Bioethics
- Scottish Secular Society
- Secular Medical Forum
- Secure Environment Pharmacists Group
- Society for the Protection of Unborn Children
- South Staffordshire Local Pharmaceutical Committee
- Spring Road Evangelical Church
- Sykes Chemists Ltd
- Terrence Higgins Trust
- The Baptist Church, Kilmington
- The Christian Institute
- The International Vegan Rights Alliance
- The National LGB&T Partnership
- The Vegan Society
- Twickenham Christian Concern
- University of Bradford
- Uttoxeter Health Stores Ltd
- Vyas ltd
• Well
1. Aims and purpose of the project/policy

1.1 This paper analyses the equality and diversity implications of proposed changes to the new standards for pharmacy professionals and supporting guidance on religion, personal values and beliefs in order to give effect to the Public Sector Equality Duty under section 149 of the Equality Act 2010. This requires the GPhC to have due regard to each of the statutory objectives, including the need to:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons
who do not share it.

1.2 Conducting an analysis of the equality and diversity implications of our proposals also helps to ensure that we are not acting in a way that is incompatible with a Convention right\(^1\).

1.3 Assessing the equality, diversity and inclusion impact of our policy development work is about being proactive in facilitating opportunities for people with the widest possible range of experiences and perspectives to engage with and influence our values, our culture, our strategy and the work we do. We aim to take an inclusive approach to working with users of pharmacy services, registrants, stakeholders and people affected in any way by our policy decisions.

1.4 This analysis includes an overview of the work we have completed to inform our understanding of the equality and diversity dimensions of the proposed changes; to identify any trends or issues that apply to people who share protected characteristics; and, to consider the potential impact on these groups. This has been informed by our quantitative and qualitative analysis of responses to the consultation; the available data and/or evidence relating to groups by reference to protected characteristics; and, our extensive engagement with a wide variety of stakeholders. The analysis is intended to assist Council in considering whether the changes to the standards should be approved and/or subject to further amendment before introduction.

1.5 We have updated this analysis at the following stages of the policy development process:

- **Stage 1**: Pre-consultation
- **Stage 2**: During the consultation and engagement period
- **Stage 3**: Post-consultation

1.6 At all stages of the process, we have considered how best to engage with equality groups, and equality and diversity issues have informed our policy development plans from the outset. In particular, we have sought to identify and mitigate any adverse impact on groups sharing protected characteristics, including both pharmacy professionals and people using pharmacy services. We have also considered how the proposed changes can help make a positive impact on these groups.

1.7 It is important to note that our assessment of the equality and diversity implications of our proposals is not just about the impact on groups whose interests are sometimes perceived as conflicting. It is also about ensuring people are protected from discrimination in all the complicated factual scenarios that exist in real life, specifically in the context of the provision of pharmacy services.

1.8 The Equality Act 2010 prohibits direct or indirect discrimination, or harassment on the basis of a protected characteristic. There is a fundamental distinction between direct discrimination, on the one hand, and indirect discrimination on the other\(^2\). Direct discrimination is where an individual receives less favourable treatment because of a protected characteristic. Indirect discrimination concerns a provision, criterion or practice that puts someone with a protected characteristic at a particular disadvantage, compared with people who do not share the protected characteristic\(^3\). However, a provision, criterion or practice that causes a particular disadvantage is lawful if it is a proportionate means of achieving a legitimate aim.

1.9 In preparing this analysis, we have considered all of the statutory objectives under Section 149 of the

---

\(^1\)The Human Rights Act 1998, Section 6

\(^2\)The Equality Act 2010, Sections 13 and 19

\(^3\)The Equality Act 2010, Section 19
Policy context

1.10 Between April and June 2016, we consulted on proposed new standards for pharmacy professionals, which are due to come into force later this year. There are nine standards that every pharmacy professional is accountable for meeting, and these describe how safe and effective care is delivered through ‘person-centred’ professionalism. Each standard is followed by examples of the types of attitudes and behaviours that pharmacy professionals should demonstrate. A full analysis of the equality and diversity implications of the new standards was completed and is available on our website.

1.11 Standard 1 said that ‘pharmacy professionals must provide person-centred care’ and gave examples of how pharmacy professionals can apply the standard. In the context of religion, personal values and beliefs, the examples we first consulted on included a requirement for pharmacy professionals to tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers. Although most respondents (around 90%) agreed with the approach proposed, the majority of those who commented in this section were of the view that pharmacy professionals should not be able to refuse services based on their personal beliefs. This, it was argued, would contradict the principle of providing person-centred care.

1.12 The new standards were approved by Council in October 2016 subject to further consultation on the examples under Standard 1 relating to religion, personal values and beliefs. The proposed changes – to which this further consultation relates – mean that pharmacy professionals will be required to take responsibility for ensuring that person-centred care is not compromised by their religion, personal values or beliefs. We believe this revised wording is compatible with our policy of person-centred care, and better reflects the relevant framework of equalities and human rights legislation (which is discussed in more detail below).

1.13 If approved, the proposals will change the expectations placed on pharmacy professionals when their religion, personal values and beliefs might impact on their ability to provide certain services, and shift the balance in favour of the needs and rights of the person in their care. While a referral to another service provider may still be appropriate, this will depend on how the referral is carried out, and the pharmacy professional must take responsibility for the continuity and/or outcome of the person’s care.

1.14 At the same time, we also consulted on new supporting guidance, which is intended to help pharmacy professionals apply the standard and reflect the broad range of situations when a pharmacy professional’s religion, personal values or beliefs might impact on their ability to provide services.

1.15 In carrying out this analysis, we have considered the potential equality and diversity implications of the revised standards, as well as the supporting guidance.

---

4 Consultation on standards for pharmacy professionals, April 2016
6 http://www.pharmacyregulation.org/sites/default/files/combined_council_papers_13_oct_16_for_website.pdf
7 Standards for pharmacy professionals: analysis of consultation responses, August 2016
8 Consultation of religion, personal values and beliefs, December 2016
2. Review of available information and/or data

Developing our evidence-base

2.1 We have carried out a systematic and evidence-based approach to our policy development, including our assessment and understanding of the equality and diversity dimensions of our proposals.

Legal framework

2.2 Our proposals have been developed alongside our review of the relevant framework of equalities and human rights legislation, which seeks to protect competing rights fairly, for example the right to manifest religious belief and the rights of others not to be discriminated against.

2.3 The current law in this area is relatively recent, based as it is on the Human Rights Act 1998 (which incorporates into domestic law the rights and liberties enshrined in the European Convention on Human Rights) and the Equality Act 2010, which consolidates multiple pieces of legislation into one single Act. New and emerging case law has also played a vital role in shaping and clarifying our understanding of the interaction between equality and human rights law, and balancing competing rights.

2.4 Our review led us to conclude that the examples proposed in the initial standards consultation were too weighted towards accommodating the pharmacy professional’s values and beliefs, as opposed to what the law requires of them as a service-provider. We felt that a more considered approach would better balance the rights of individual pharmacy professionals, and the rights and needs of their colleagues and service users.

2.5 The revised examples and supporting guidance reflect our understanding of the law in this area, and in our view strike the right balance in protecting the religious freedom of pharmacy professionals and preventing discrimination against service users. In essence, the revised approach makes clear that the bottom line is that the people whom pharmacy professionals are there to serve should receive the care and advice they need. The onus is on pharmacy professionals to ensure that they are not in a position where refusal to provide services would result in a person not receiving the care or advice they need, or breach human rights or equality legislation.

2.6 The proposed guidance specifically highlights religion and belief as well as personal values, as these can particularly impact on professionals’ decision-making in practice. Having sought advice from the Equalities and Human Rights Commission, we are satisfied that this wording does not raise any equalities issues. This is because the guidance clearly indicates that all protected characteristics have equal status. Further, the guidance makes it clear that in terms of equality legislation religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

2.7 We believe that the proposals accord with our over-arching objective which is the protection of the public.

---

9 The Equality Act 2010, Section 10
10 The Pharmacy Order 2010, Article 6(1)
2.8 We envisage that the proposals will necessitate changes to the way some pharmacy professionals currently work, including the need to have early discussions with employers about the way in which religion, personal values or beliefs might impact on service provision. Clearly, this could bring more challenges for employers who rely on professionals working alone or in isolation, particularly in rural areas, or where there is a shortage of staff or locums. However, we believe that ultimately this will lead to the creation of open and honest work environments, and encourage proactive ways of working to ensure consistent and non-discriminatory service-provision, taking into account the needs of individual patients.

2.9 Overall, we believe that the proposals are fair and justified as good for both pharmacy professionals and service-users. We consider that the proposals will advance equality and further good relations between different groups. Insofar as the proposals might have an adverse effect on people with protected characteristics we consider that it is a proportionate means of achieving a legitimate aim, or aims – and are therefore lawful.

Landscape of religious affiliation and identity

2.10 As part of our equality and diversity analysis, we have sought to understand the landscape of religious identity and affiliation in Britain, including the general public and registered pharmacy professionals. This is important both in terms of our engagement strategy, and in helping us to understand how different religious - or non-religious – beliefs might shape or influence perspectives on the provision of pharmacy services.

2.11 In terms of the general public, the Equalities and Human Rights Commission has reported that Britain today is simultaneously a Christian, religiously plural and secular society, although arguably becoming more secular, more religiously plural and less Christian11. The report summarises census data, which shows that between 2001 and 2011 the proportion of the British population identifying as Christian declined from 72% to 59% per cent; while the proportion identifying as ‘no religion’ increased from 15% to 26%. Over the same period, the proportion of Muslims rose from 3% to 5% and the Hindu, Sikh, and Buddhist proportions rose slightly, whereas the Jewish proportion remained broadly similar. The report indicates that there has been a marked increase in the membership of evangelical Pentecostal Churches and New Churches and a decline among longer established Christian denominations, especially Catholics, Methodists and Presbyterians.

2.12 Further census data is available from both the Office for National Statistics12 and the website for the Scottish Government13.

2.13 In autumn 2013, we commissioned NatCen Social Research to carry out a survey of registered pharmacy professionals. All pharmacy technicians (21, 672) and a large probability sample of pharmacists (30,040) as well as pharmacist prescribers were invited to take part in the survey asking about their work, practice and responsibilities. Over 29,000 registered pharmacy professionals responded to the survey; 15,553 pharmacists and 13,515 pharmacy technicians. This is the first survey of its kind carried out by the GPhC and it provides important insights into distinct areas including employment, responsibilities and appraisals14.

12 https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion
13 http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Religion/RelPopMig
2.14 The survey included findings relating to religion or belief. Registrants were asked to which, if any, of a list of religions they considered that they belonged: 48% of pharmacists reported that they were Christian, 13% were Muslim and 12% were Hindu. A fifth of pharmacists (20%) stated that they did not belong to any religion. Just under two thirds (64%) of pharmacy technicians reported that they were Christian. Just over a quarter (26%) stated that they do not belong to any religion.

2.15 We have therefore sought to ensure that these different groups were represented throughout our consultation and engagement process. In analysing the responses to our consultation, we have also highlighted the differences between two pairs of subsets of respondents: members of the public and pharmacy professionals; and respondents with religious beliefs and with no religious beliefs. The rationale for presenting results for these subsets, and the methodology for creating these groups, is set out in detail in the full consultation analysis.

Inequalities in healthcare

2.16 A recent NHS England report on equality in public facing functions indicates that there are inequalities in access, health outcomes and service experience, which have endured over time despite substantial investment in healthcare. The report highlights that inequalities are evident between groups of people with different characteristics, and across geographies.

2.17 The Equalities and Human Rights Commission has also highlighted that “religious tenets may inform an individual’s views about social issues, such as marriage and sexual relations, the role of women, transgender identity, and disability. This may sometimes have an impact on their behaviour at work, when providing or using services and in other public environments. This may result in tensions between people with and without a religion, between people of different religions, or between people with a religion and those with other protected characteristics.”

2.18 Such tensions clearly exist within the pharmacy sector, and religion, personal values and beliefs can affect the provision of pharmacy services. Through our equality analysis, we have sought to understand the key issues faced by people in their daily lives due to religion, personal values and beliefs, both from the perspective of the service-user and the service-provider. We have heard from pharmacy professionals who object to providing certain services due to religion or belief, and we heard examples and reports of patients being turned away from pharmacies without any signposting or referral to alternative services, or being treated without dignity and respect. The issues for both groups have been explored in detail and incorporated into the impact assessment in Section 8 below.

3. Screening for relevance to equality and diversity issues

<table>
<thead>
<tr>
<th>Does this project/policy have any relevance to (delete as appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender reassignment</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage and civil partnership</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>Yes</td>
</tr>
<tr>
<td>Race</td>
<td>Yes</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>Yes</td>
</tr>
<tr>
<td>Sex</td>
<td>Yes</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Yes</td>
</tr>
<tr>
<td>Welsh language scheme</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Full EIA</strong></td>
<td>Yes</td>
</tr>
</tbody>
</table>

4. From the answers supplied, decide what further work needs to be undertaken if the proposals impacts upon diversity or equality issues

4.1 If approved, the proposed changes to the new standards and supporting guidance will apply to all pharmacy professionals. This will also serve as clarification to the public about what they can expect from pharmacy professionals in this context, specifically around the provision of services affected by religion, personal values and beliefs.

4.2 Pharmacy professionals and owners will need to consider a number of factors to ensure that person-centred care is not compromised by religion, personal values or beliefs, including:

a. issues relevant to where they work, including location, opening hours and range of expected services;
b. the need for open and honest conversations with employers;
c. the individual needs of the person in each case, including any barriers in accessing care and/or services;
d. how to use their professional judgement to make sure the person receives the care or advice they need, when they need it;
e. how to safeguard and respect a person’s dignity and privacy; and
f. whether referral is an appropriate option based on the individual needs and circumstances of the person in their care.

4.3 The potential impact of these changes, from an equality and diversity perspective, has been included in the full impact assessment in Section 8 below.

5. Consultation / Involvement

5.1 Equality and diversity informed our consultation and engagement strategy from the outset. We used a wide range of communication activities to maximise participation in the consultation across a diverse range of stakeholder groups, as well as general and targeted engagement approaches to reach all potential audiences. Below is a summary of our extensive consultation and engagement activity:
a. Consultation launched via a press release on 13 December 2016\textsuperscript{17}  
b. Interviews with P3 Magazine and Pharmaceutical Journal in advance of the launch; both publications published related articles  
c. Video-taped interview for ‘chemistanddruggist.com’ on 24 January 2017  
d. Articles in the GPhC online blog ‘Regulate’  
e. Emails to all registrants and stakeholders with a link to the online survey, concurrent with the launch (potential respondents were invited to respond via an online survey, by email or by post. Hard copy, large font and other language versions of the document were available on request)  
f. Follow up emails to registrants and stakeholders in January 2017  
g. Further reminder emails to registrants and stakeholders in late February 2017  
h. Provision of a content ‘tool kit’ with pre-written news stories and twitter posts to help stakeholders promote the consultation through their networks  
i. Members of staff on hand to answer any questions throughout the consultation process  
j. Multiple trade and national press articles relating to the consultation

**Patient focus groups**

5.2 We held focus groups in London, Cardiff and Glasgow, which allowed us to discuss the consultation questions in depth with patients and the public. Feedback gathered through these groups is not intended to be seen as representing the views of all patients and members of the public, but rather a snap shot of a variety of views to inform our work. We also encouraged attendees to engage with our consultations through our network of patient and protected characteristic organisations promoting our consultations; through one-to-one meetings with organisations representing particular groups of people, including those with protected characteristics; and, through social media.

5.3 We recruited focus group participants using the following methods:

a. **Through our existing patient panel:** this is a group of 200 individuals who participate in focus groups and online activities. This group was recruited by Saros (a recruitment partner for market research) and is broadly representative of the British population in terms of gender; age group; ethnic background; working status; social grade; family composition; disability and long term conditions; and recent health experience. Panel members are not registered pharmacy professionals, and are not part of a panel used by another health regulator.

b. **Through networks with a particular interest in health:** this includes Healthwatch in England, Community Health Councils, Diverse Cymru in Wales, and the Alliance in Scotland.

c. **Through Saros:** a recruitment partner for market research, who recruit individuals to participate in focus groups on a one off basis when additional numbers are needed. We asked Saros to recruit attendees who were broadly representative of the British population in terms of age, gender and ethnic background, and to exclude anyone working in pharmacy.

**Pharmacy focus groups and roundtables**

5.4 We held engagement events in Cardiff, Glasgow and London, as well as an additional roundtable meeting in London. These events were attended by a diverse mix of groups and organisations representing the pharmacy sector. This included representatives from professional membership bodies for pharmacists and pharmacy technicians; multiples and independent pharmacies; education

\textsuperscript{17}https://www.pharmacyregulation.org/news/gphc-consults-religion-personal-values-and-beliefs-pharmacy-practice
and training; NHS organisations; public health organisations; community and hospital pharmacy; and other stakeholders.

Additional one to one meetings

5.5 We were particularly mindful of the need to engage with diverse groups, including organisations and groups representing those with protected characteristics. In addition to the general stakeholder invitations, we proactively invited a number of different groups to individual meetings, including:

a. Religious groups and organisations
b. Secular and humanist groups and organisations
c. Groups representing pharmacy professionals and doctors with different religious beliefs
d. Groups representing pharmacy professionals and doctors with secular and humanist views
e. Sector interest groups, including pharmacy law and ethics, secure environments, health and justice, and hospital pharmacy
f. Patient and other advocacy and support groups and organisations

5.6 In total, we held one to one meetings with 29 different groups and organisations during the consultation period. The full list attached at Annex A.

6. Date and method of consultation

6.1 The original consultation on the standards for pharmacy professionals was open for 13 weeks (4 April to 27 June 2016).

6.2 This further consultation on Standard 1 was open for 12 weeks (13 December 2016 to 7 March 2017).

6.3 Please refer to our analysis of consultation responses for further detail on the methodology.

7. Give a brief summary of the results of the consultation / involvement. How have these affected the proposal?

7.1 Please refer to our analysis of consultation responses for details of the outcomes.

7.2 All issues relating to equality and diversity identified through the engagement and consultation process have been set out in detail in Section 8 below.

8. Full impact assessment

Explain the potential impact (whether intended or unintended, positive or adverse) of the proposal on individual groups on account of:

Age – consider impact on people of different ages such as young or old.

Different age groups will have different and distinct healthcare needs and concerns. As part of our
engagement activity, we have sought to assess the impact of our proposals on people of different ages.

We conducted a focus group with around 60 members of the Redbridge Pensioners Forum in January 2017. Broadly, the older people who attended the event supported the principle of person-centred care in pharmacy and recognised the importance of pharmacy professionals adapting their care and advice to suit the needs and concerns of the patient. In the context of religion and belief, the group generally felt that it is important for pharmacy professionals to think about the barriers that a patient might face when deciding if a referral is appropriate.

A number of individuals and groups who responded to the consultation suggested that young women might face particular difficulties in accessing services such as emergency hormonal contraception (EHC) if turned away from one pharmacy. This is discussed in more detail below.

Our quantitative analysis also identified some noticeable differences between the subsets of respondents to our consultation in terms of age profile. As with other characteristics, the age profile of pharmacy professionals responding to the survey is broadly similar to the GPhC’s register. The age profile of members of the public strongly tends towards older age groups, with 21.8% of respondents aged 50-59, and 43.9% aged 60 years or older.

We believe that the proposals will help to mitigate any risk that people of different ages will be treated unfairly by requiring pharmacy professionals to take a person-centred approach and adapt their care to meet the needs and concerns of the person. We do not envisage any other significant equalities impact of the proposals in relation to age.

### Disability – consider environmental, social and attitudinal barriers

People with disabilities face a number of barriers in accessing healthcare. A number of people who attended our engagement events felt that being asked to travel to another pharmacy to access a service could have a negative impact on people with a disability. Indeed, there is existing evidence and research to indicate that access to health and social care facilities for people with a disability can be an issue. This Consumer Council research indicates that the method of transport people use to travel to health and social care facilities usually depends on where they live and the nature of their disability.

Mencap has recently led a project investigating pharmacy provision in partnership with Scope, the National Autistic Society and Sense. The report found that that negative experiences of pharmacy services are not the norm. However, it was clear that a number of barriers exist such as access to information, clear communication, and explanation of the purpose of medicines.

We have also learned from Mencap that asking people to access alternative facilities could cause a significant additional barrier for someone with a learning disability. It may be very difficult for that person to understand a decision not to provide treatment, or to understand specific instructions about returning to the pharmacy at a later time, or accessing a different pharmacy altogether. This means there may be a risk of the initial refusal being misinterpreted as permanent.

Further, we heard that it can be difficult for some people with a learning disability to understand directions, times and dates; therefore, the act of returning on a different day or visiting a different facility could pose a significant barrier. In addition, if someone is reliant on support from a family carer or support staff, they

---

18 Transport issues in accessing health and social care services, The Consumer Council, March 2013
19 The Disability Partnership’s Pharmacy Project, 2015/16
may need to wait until this individual is able to support them again. This can have an impact as some people may only receive support once or twice a week.

Mencap have also reported that the types of services and treatments listed in our draft guidance can be complicated to use and understand, making it even more important that an individual is able to access the treatment with as few barriers, and as much support, as possible. In the case of contraceptive products and sexual health services, people with a learning disability are likely to have already encountered significant barriers to having a sexual relationship in the first place. These can be practical barriers, for example, being able to get out and meet new people and also barriers which come from the attitudes of other people in society, who can disapprove of someone with a learning disability having a sexual relationship; this may include the individual’s own family and support networks.

Overall, we believe that the proposals will help to mitigate any risk that people with a disability will be treated unfairly by requiring pharmacy professionals to take a person-centred approach and adapt their care to meet the needs and concerns of the person. This includes consideration of the barriers that people with a disability might face when accessing services. We do not envisage any other significant equalities impact of the proposals in relation to disability.

Gender reassignment – consider impact on transsexual and transgender people including bullying, harassment and discrimination issues not least ensuring privacy of data to avoid disclosure of gender history.

There is a significant amount of evidence and information, which highlights the inequalities and high levels of discrimination trans people face including within health and social care. There is also evidence that, within health and social care, there are some major gaps in the knowledge and training of staff relating to trans people, which is resulting in unfair treatment of both patients and colleagues.

The needs of every person are different, but through our engagement work we have heard examples of the difficulties that trans people face in the context of pharmacy. For example, a person identifying as male may require access to emergency hormonal contraception. We have heard of examples where the patient has felt embarrassed by the way the request was handled by the pharmacy professional, or where patients have not been treated with dignity and respect when trying to access advice and services from pharmacies.

In response to our first consultation on the standards, the Gender Identity Research and Education Society (GIRES) expressed the view that person-centred care “should prevent the possibility for pharmacists to pass a person on to someone else because they don’t ‘approve’ of the use of particular products for particular people, owing to their own religion or belief.” In response to this subsequent consultation, GIRES have indicated that they are pleased to see that the draft guidance mentions gender reassignment and highlights that all protected characteristics have equal value. Additionally, the British Association of Gender Identity Specialists has indicated support for the proposed approach and considers that the impact of the proposals on people will be mostly positive as it assures confidence.

Overall, we believe that any potential inequalities for this group have been mitigated by the proposed focus on person-centred care and the subsequent extension of the draft guidance to include references to equality law, a full range of services and the way in which people should be treated by their pharmacy professionals. We do not envisage any other significant equalities impact of the proposals in relation to gender reassignment.

21 Unhealthy attitudes: The treatment of LGBT people within health and social care services, Stonewall and YouGov
**Marriage or Civil Partnership** – consider impact on married people or people in a civil partnership, young or old

We do not envisage any significant equalities impact of the proposals in relation to marriage or civil partnership.

**Pregnancy or maternity** – consider impact on pregnant women and those on maternity leave

We have addressed the potential impacts in relation to pregnancy and maternity in the context of the impact on sex below.

**Race** – consider impact on people of different ethnic groups, nationalities, gypsies, travellers, languages etc.

As part of our engagement activity, we met with the Race Equality Foundation – a group which works to promote race equality in social support and public services by exploring what is known about discrimination and disadvantage, and developing evidence-based better practice to promote equality. This group indicated support for the revised approach, which they believe focusses on person-centred care, and provided a number of examples about how pharmacy professionals might demonstrate this in practice. For example, the group raised the importance of pharmacy professionals having knowledge of the needs of the particular community where they work. This includes religious, social or cultural differences which might impact on the needs of individual patients.

We also contacted ‘Friends, Families and Travellers’ – a group which works to end discrimination against Gypsies, Roma and Travellers whatever their ethnicity, culture or background, whether settled or mobile, and to protect the right to pursue a nomadic way of life. We learned that there are problems with some of the travelling community accessing healthcare, with many preferring to go to A&E. It is estimated that up to 61% of the travelling community have low rates of literacy, which means that some would not be aware of services offered by healthcare providers.

Overall, we believe that any potential inequalities based on this protected characteristic have been mitigated by the proposed focus on a person-centred care in the standard and the subsequent extension of the draft guidance to include references to equality law, a full range of services and the way in which people should be treated by their pharmacy professionals. We do not envisage any other significant equalities impact of the proposals in relation to race.

**Religion or belief** – consider impact on people with different religions or beliefs, or none

Everyone has the right to be treated with fairness, dignity and respect and this includes respect for a person’s religion or belief, and respect for the rights of others. The standards and guidance deal with the balance between the rights of the pharmacy professional to practise in accordance with their religion or belief and the rights of patients to access the care and advice they need, when they need it.

As part of our engagement process we proactively sought input and discussions with a number of religious and secular groups, as well as a diverse range of patients and patient groups, in order to assess the equality and diversity implications of the proposals.
a. Patients

Patients have the right to be treated fairly and with respect whatever their religion or belief. Many respondents saw the proposals as a positive step in further strengthening person-centred care in pharmacy; recognising the positive impact this would have on different groups of service-users, by giving them more consistent access to services.

Some respondents have highlighted that pharmacy professionals need to be aware of and sensitive to the many different needs and perspectives of patients. For example, individual patient reactions to clinical situations can be influenced by their religion or belief, or the strength of their beliefs. As a result every person needs to be treated as an individual and those providing care and advice need to be sensitive to cultural, social, religious or spiritual factors, as well as clinical factors.

A number of respondents have highlighted that while pharmacy professionals should not impose their own beliefs on a patient, they should not shy away from discussions where it relates to the person’s care (for example, advice on taking medicines during periods of fasting). Others have commented that some patients are sympathetic to the values and beliefs of their professionals, and prefer to see a professional who shares their views. A number of respondents said that patient care could be compromised if a professional felt as though they were being asked to provide services against their conscience.

b. Pharmacy professionals

Pharmacy professionals have the right to practice in accordance with their religion or belief provided they act in accordance with equalities and human rights law, and ensure that the care of patients is not compromised. In terms of equality and diversity, the main concerns raised throughout the consultation process relate to potential discrimination against pharmacy professionals and breach of Article 9 of the European Convention on Human Rights, namely the right to freedom of thought, conscience and religion. Some have raised concerns about the tone of the draft guidance. Conversely, others argue that the new approach is more in line with human rights and equalities legislation.

The revised standard and related guidance reflects our understanding of the law in this area, and in our view strike the right balance in protecting the religious freedom of pharmacy professionals and preventing discrimination against service users. In terms of language and tone, the draft guidance recognises the importance of a pharmacy professional’s religion, personal values and beliefs. However, we will review the wording to ensure the rights of pharmacy professionals are appropriately recognised.

c. Discrimination, victimisation or harassment in the workplace

A number of groups and individuals have argued that the proposals could be misused by employers to discriminate against employees based on their religion or belief. On the other hand, many respondents have argued that employers must comply with the law and believe that the proposals will create a more open and honest environment, with clearer expectations on those delivering pharmacy services.

Some have suggested that employers will need to put in place new systems for service delivery and staffing, but overall the proposals will result in a better and more consistent service for patients. For example, the Association of Pharmacy Technicians has argued that the proposals will encourage employers and
employees to have open and honest discussions, and to put in place proactive ways of working to cover any eventuality.

As part of our policy development process, we have also considered a recent report by the Equality and Human Rights Commission (EHRC)\(^ {22}\), which explores whether Great Britain’s equality and human rights legal framework sufficiently protects individuals with a religion or belief and the distinctiveness of religion or belief organisations, while balancing the rights of others protected under the Equality Act. The assessment reflected the statutory duty placed upon the EHRC to monitor the effectiveness of equality and human rights legislation and make recommendations to the government about any changes that might be necessary. The evaluation focussed on the following questions:

a. Is the legal approach to defining a religion or a belief effective?
b. Are the Equality Act exceptions allowing religion or belief requirements to influence employment decisions sufficient and appropriate?
c. Does the law sufficiently protect employees wishing to manifest a religion or belief at work? [our emphasis]
d. Does the law sufficiently protect service users and service providers in relation to religion or belief?

In relation to the third question, the EHRC found that the legal framework should remain unchanged because the existing model of indirect discrimination and the concept of balancing rights in human rights law provide sufficient protection for people manifesting their religion or belief.\(^ {23}\)

The EHRC recommended that a duty of reasonable accommodation should not be introduced into law. In particular, they highlighted that the existing law does not prevent an employer from making an accommodation, unless doing so would breach discrimination law or other legal requirement such as health and safety legislation. The EHRC indicated that employers should already seriously consider every request made for reasons relating to religion or belief, both as a matter of good practice and to avoid the risk of indirect discrimination. Further, they recommended that individual employees should not be permitted to opt out of performing part of their contractual work duties due to religion or belief where this would have a potential detrimental or discriminatory impact on others.

The EHRC also highlighted the recent announcement by HM Courts and Tribunals Service that it intends to publish new Employment Tribunal judgments online. They consider that this will make judgments more accessible to everyone and help build understanding of the way in which equality and human rights law protects the rights of people with a religion or belief and other rights and individuals protected in law.\(^ {24}\)

There is already a wealth of information, advice and support available on creating fair workplaces and preventing discrimination from organisations such as ACAS and other recognised sources. This is available to all pharmacy professionals and highlighted in our draft guidance.

Ultimately, employers must not discriminate against pharmacy professionals because of their stated or perceived religion, personal values or beliefs. We consider that we have helped to mitigate this risk by including clear statements to this effect in our draft guidance. However, we will consider further how we

\(^ {22}\) Equality and Human Rights Commission Report ‘Religion or belief: is the law working?’ December 2016


\(^ {24}\) https://ids.thomsonreuters.com/download/file/fid/55657
can reinforce the responsibilities of employers to prevent potential discrimination or harassment in the workplace.

**Sex – consider impact on men and women; working arrangements, for example, part-time, shift working, caring responsibilities.**

Evidence and feedback collated throughout the engagement process has demonstrated that women seeking certain advice or services such as contraception may be unfairly disadvantaged or discriminated against in this context. Anecdotal evidence has highlighted a number of inequalities in access, health outcomes and service experience for women, including women of different ages.

We met with the British Pregnancy Advisory Service (BPAS), which is a reproductive health charity that sees 80,000 women a year with unplanned pregnancies or pregnancies they feel they cannot continue. As part of their charitable remit, BPAS advocates for reproductive choice and are running the 'Just Say Non' campaign which aspires to make Emergency Hormonal Contraception (EHC) more accessible in pharmacies both in relation to price and other barriers.

One of the services offered by BPAS is contraception counselling. They report that during consultations with patients, as well as a result of their advocacy work on emergency hormonal contraception (EHC), women inform them about the barriers in accessing EHC in pharmacy. We heard that these barriers relate to the personal beliefs of pharmacists, or the perception that pharmacists are able to discriminate against women requesting contraception unlike any other group of patients. In response to our consultation BPAS asked its contraception nurses, who provide contraceptive counselling for women who have attended BPAS for an abortion, to record women’s experiences of trying to obtain, or obtaining, EHC before coming to BPAS. The following testimonies were recorded in February 2017:

- ‘She said that she was unable to help and that I need to go to another pharmacy. She looked at me as though I was a piece of dirt”
- ‘It took me a couple of attempts to join the queue and when I got there and asked for the morning after pill he said it was against his religion to give it to me. I was so upset, I left and didn’t bother trying anywhere else”
- ‘(They) literally chucked it at me and said I should [see] my doctor and get proper contraception.”
- ‘It wasn’t what he said but it was look he gave me - so dismissive and cold. I couldn’t wait to get out of there’
- ‘He said he could not deal with me and that I would have to wait for another pharmacist to come back from lunch”
- ‘(They) treated me as though I was a kid. I am 35 with two kids!’

BPAS highlight that these case studies show that refusal to provide EHC to women has a profoundly negative impact on those patients, and risks pregnancy and abortion. Pregnancy has a clinical risk attached to it regardless of the outcome and refusal to provide EHC could have a detrimental impact on the health and wellbeing of patients.

On the other hand, we learned of positive examples of person-centred care, including situations where pharmacy professionals took time to explain contraceptive options and treated patients with dignity and respect.

BPAS also raised concerns that a refusal to dispense EHC could have a negative impact on certain groups such as young women, who may be nervous or embarrassed to go and find another pharmacy and explain their situation again at a counter in a public environment. They commented that in other countries empty
boxes or laminated cards are placed on shelves so women do not have to endure the humiliation of talking about their sex life in public. This does not happen in Britain.

We heard that if the care delivered is woman-focused and responsive to the needs of the patient, pharmacy professionals can play an important role in women’s health. However, those who stigmatise women on the basis of their personal views about EHC, or women’s choices, damage the reputation of the profession and make it less likely that women will approach pharmacists as a source of non-judgmental advice and support.

Overall, we believe that the proposals will help to mitigate the risk that women do not receive a fair and non-discriminatory service from their pharmacy professionals across Great Britain. We also consider that the proposals will help to advance equal opportunities for women seeking advice and services.

Sexual Orientation – consider impact on bisexual, gay, heterosexual or lesbian

There is substantial evidence to demonstrate that LGBT people experience significant health inequalities, which impact both on their health outcomes and their experiences of the healthcare system. As part of our consultation and engagement process, we have spoken with a number of different groups in order to identify issues and inequalities experienced by LGBT people within pharmacy and to discuss the impact of our proposals.

The National LGB&T Partnership highlighted the limited research into LGBT people's experiences of accessing pharmacy services (Rainbow Hamlets, 2015), which stated:

a. Just 15% of LGBT+ people questioned were open about themselves with a pharmacy they see regularly on medical matters.

b. There are strong indications from interviews and free text responses that LGBT people travel away from their home to use pharmacies if they wish to reveal aspects of their identity.

c. 61% of LGBT+ people who had lived with, or were now with, a partner (35% of entire sample) had not revealed the household to any pharmacist.

d. 23% of LGBT+ people surveyed had direct experience of inappropriate responses to their sexual orientation or gender identity from pharmacy personnel. These are all in contravention of the Equality Act as it relates both to goods and services and to the public sector equality duty.

e. 37.5% of LGBT+ respondents reported there were pharmacies near their home where they did not feel comfortable.

f. 50% of all LGBT+ respondents had either experienced discrimination first hand or had formed an impression that a pharmacy near their home would not be welcoming to them.

g. Many respondents identified explicitly that culture and faith played a large part in both trust issues and direct experience of prejudice.

h. A dedicated LGBT+ awareness programme for pharmacies would radically improve the likelihood that LGBT+ people will reveal themselves more fully to their pharmacist. It is also likely to improve take up of local services and address the poor responses to LGBT+ interactions experienced by 23% of respondents. The patterns of pharmacy usage described earlier suggests that there are numerous neutral interactions for toiletries or medications during which LGBT people may be visiting a local pharmacy. What they see or hear on that occasion will help them to re-evaluate the

---


26 http://www.rainbowhamlets.org/health-and-wellbeing/research/
risk of being out.

We also learned that the LGBT Foundation, lead partner of the National LGB&T Partnership, is currently conducting a survey into LGBT people’s experiences of all primary care services, including community pharmacies, as part of its Pride in Practice programme. This may provide further examples of people’s experiences in pharmacy in the future.

Overall, these groups were supportive of the new standards, highlighting that the standards demonstrate how pharmacy professionals should always ensure that the individual receives person-centred care on every interaction. We heard that the revised standards have the potential to have a very positive impact on LGBT people using pharmacy services. However, we also learned that there is still work to be done in changing conceptions held by LGBT people about accessing pharmacy services.

We also heard about the importance of encouraging pharmacy services to work with the LGBT voluntary sector to become fully inclusive and accessible for LGBT service users. This would help to break down the real and perceived barriers that will likely stop LGBT people accessing pharmacy services when they need them.

We believe that the proposals will help to mitigate any risk that LGB&T people will be treated unfairly or in a discriminatory way by requiring pharmacy professionals to take a person-centred approach and treat people fairly, with compassion and with respect.

Other diversity and equalities related issues

We have also considered the following equalities related issues:

a. NHS contracts

A number of respondents have questioned whether the proposals could have an impact on contractual arrangements. The draft supporting guidance already states that pharmacy professionals must consider the contractual responsibilities of their employer, including any in the NHS Terms of Service. We will explore whether references to contractual issues should be expanded in the draft guidance when this is reviewed.

b. Access to services

The draft guidance advises pharmacy professionals to think about any specific barriers the person may face – for example, difficulty in accessing the services they need. Indeed, many respondents have raised location and access to services as examples of barriers for groups such as disabled people or young women, who may be unable to visit a second pharmacy.

Issues relating to access were also raised in a recent High Court ruling where the NHS Litigation Authority was found to have acted entirely lawfully in its decision not to grant an application by Community Pharmacies to relocate a pharmacy, partly because of the potential impact on women seeking emergency hormonal contraception.

Some people have argued that the changes could have an impact on those working alone or in isolation, particularly in rural areas, or where there is a shortage of staff or locums. Community Pharmacy Wales has

---

27 R (on Application of Community Pharmacies [UK] Limited) v The National Health Service Litigation Authority, Case number: CO/6383/2015
highlighted that a large number of pharmacies in Wales are in rural or isolated communities. However, they do not consider that providing pharmacists with an option to signpost to another provider, when their beliefs are challenged is a viable solution.

c. Pharmacy students

Some groups and individuals have argued that the proposals could deter people from entering the pharmacy profession. Others such as the Pharmacy Schools Council have argued that the patient and delivery of care should always be the priority and recognise that the change is intended to encourage a pro-active approach to patient needs. Further, the British Pharmaceutical Students’ Association agreed with the sentiment in the new standards, highlighting that it is imperative for pharmacy professionals to deliver optimal person-centred care to patients and the public. However, some concerns have been expressed that the changes could be detrimental to a small minority of pharmacy professionals, who could potentially feel marginalised.

In order to mitigate any potential adverse impact on students, the Pharmacy Schools Council has offered to work with the GPhC going forward to ensure that the change is communicated effectively to students and to consider further work about how to help students raise concerns about conflicts early in their careers.

d. Safeguarding and protection against abuse

A small number of respondents have questioned the impact on safeguarding cases, with some arguing that removing a pharmacy professional’s right to question treatments on a moral basis reduces the likelihood of them intervening where there are concerns about child sexual exploitation. On the other hand, more respondents have argued that issues of safeguarding are more likely to be picked up, due to the emphasis on person-centred care and the focus on understanding the individual needs of the person. Some people felt that by simply refusing supply, without engaging the patient in conversation, professionals could potentially miss opportunities to identify safeguarding risks.

The draft guidance already asks pharmacy professionals to consider when a person may need additional care or advice, for example, vulnerable people or a case of safeguarding. However, we will consider whether there is sufficient information to ensure that safeguarding cases are handled appropriately.

e. Euthanasia and assisted suicide

A number of respondents, both individuals and groups, have argued that the proposals could compel pharmacy professionals to be involved in cases of euthanasia or assisted-suicide.

Both active euthanasia and assisted suicide are illegal under English law. In England, Wales and Northern Ireland, assisting a suicide is a crime. There is no specific crime of assisting a suicide in Scotland. But it is possible that helping a person to die could lead to prosecution for culpable homicide. The Royal Pharmaceutical Society has a position on assisted suicide and has indicated, through this consultation process, that this is an extreme case and not to be confused with routine pharmacy practice. They consider that there are many legal complexities around dispensing a prescription for an assisted suicide procedure, which would need to be addressed in the future.

It will be for the law-makers to decide on any future change to the law in this area. It would be

---

29 https://www.dignityindying.org.uk/assisted-dying/the-law/
30 http://www.rpharms.com/political-issues/assisted-suicide.asp
inappropriate for us to reference or speculate in standards or guidance about the implications of any hypothetical future legal change in this area. However, it is important to confirm that any significant change in the law, euthanasia or assisted suicide being examples, would necessitate an immediate review of our standards and guidance.

f. Impact on other healthcare professions

A number of groups and individuals have argued that the proposals are inconsistent with the standards set by other healthcare regulators, specifically Good Medical Practice set by the General Medical Council (GMC) and explanatory guidance. We reviewed the position of other regulators and organisations as part of our initial policy development work. In particular, we sought input from the GMC, who having read the proposals in this consultation, believe they are in line with the standards that they set for doctors.

g. Health and Justice

We have considered the impact of our proposals on those in the criminal justice system, or within other secure environments.

We engaged with NHS England, Health and Justice Commissioning – a group which directly commissions healthcare and pharmacy services for people in residential secure environments. Those service providers include pharmacy professionals. This group highlighted that their population have diverse social, religious and ethnic backgrounds, so the consultation is important in enabling them to access high quality care from pharmacy staff. We learned that people who have been in custody could also be subject to social discrimination by pharmacy professionals. Overall, we heard that the proposals reflect an improved approach, which supports pharmacy professionals in delivering patient-centred care.

We also sought input from the Secure Environment Pharmacists Group. We heard that while it is right that pharmacy professionals are able to exercise their own values and beliefs, it is also right that people accessing pharmacy services should expect a consistent standard of person-centred care from the service provider. The proposed change in expectation placed on pharmacy professionals would mean that a consistent service could be delivered, through proactive management rather than as a reactive response to a situation as may occur currently.

h. Range of services

We have learned through our consultation process that pharmacy professionals may have an objection to providing a variety of services and medicines, and these have been incorporated into our draft guidance. The feedback collated through the engagement process has evidenced that the draft list (while not exhaustive) is a fair reflection of those services. For example, we heard from the Guild of Healthcare Pharmacists that although EHC is the most obvious ‘contentious’ service for their members, this is not the only relevant service. We heard that some people consider that methadone supply is wrong, as well as those who object to dispensing hormonal treatments supplied to trans patients. Below is some of the feedback collated in relation to the specific services:

**HIV services**

As part our engagement process, we spoke with the Terrence Higgins Trust – an organisation with a vision where people with HIV live healthy lives free from prejudice and discrimination, and good sexual health is a

---

31 Personal beliefs and medical practice, http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf
right and reality for all. The organisation’s interest in the consultation stems from the diverse range of clients that they support and many of those living with HIV access pharmacy services in order to obtain their HIV antiretroviral treatment, or medication for comorbidities.

We learned personal values and beliefs can sometimes mean that people do not access the healthcare they require. We heard that the communities they serve are often marginalised and face stigma, or have a fear that they will face stigma, even within healthcare settings. We also heard that it is important for all professionals working in a healthcare setting to have adequate training, standards and guidance to enable them to deliver a positive and respectful service to members of the public, and to prevent barriers to care. We learned that the new standards will reassure people using pharmacy services that they can expect to have a positive and inclusive experience.

The LGB&T Foundation also shared a poignant real life example from their partner organisation, the Gender Identity Research and Education Society (GIRES) of what they consider to be a lack of person-centred care in pharmacy in this context:

‘A young Asian man appeared very anxious to talk privately with the pharmacist. The pharmacist kept asking him what he wanted in a loud voice, so that other people were beginning to stare. The young man became tearful, and said something in an undertone. The pharmacist replied, loudly enough for others to hear, ‘if you want help with HIV situations, it’s no use coming to us. Pick up a leaflet’ and pointed to the area where leaflets were displayed. In addition to the embarrassment of having the young man’s possible HIV status made apparent to the half dozen people waiting to be served, there may also have been cultural issues, which made it difficult for him to follow the more obvious avenues for HIV care. The situation would have been improved if the pharmacist had considered these sensitivities and the needs of the patient.’

**Mental health services**

We heard from MIND that they are committed to a person-centred approach to care and support and would therefore be supportive of any move designed to strengthen people’s rights to get the help they need and want from pharmacy services.

**Substance misuse**

Evidence shows that people with a history of drug dependency are heavily stigmatised and are seen as both blameworthy and to be feared. As a result they are subject to exclusion and discrimination in many areas. A report by the UK Drug Policy Commission found that stigma experienced by drug dependent users and their families often delays people seeking help. The report highlighted that people fear that once they do, they will be stuck with the label ‘hopeless addict’ for life. It also pointed out that professional attitudes all too often reinforce stigma and lower expectations of recovery. Stigma puts barriers in the way of recovery and reintegration, for example by making it difficult to find a job.

The report indicated that stigma is widespread and has a significant impact on recovery once in treatment. Further, stigma was found to have occurred in a wide range of settings, including pharmacies. However, the report also highlighted some examples of good practice where professionals were supportive.

The report also looked at the need to share good practice and while the study included many examples of stigmatising practices in pharmacies and GP practices, examples were also given of positive examples that could be promoted.

---

32 Getting serious about Stigma: the problem with stigmatising drug users, UK Drugs Policy Commission, 2010
Through our own engagement, we have heard from pharmacy professionals who strongly oppose illicit drug use, but provide substance misuse services to meet the needs of the person. We heard from people working extensively in substance misuse about examples where pharmacy colleagues refused to dispense methadone treatments, and referred the patient to other providers, even where there was no other pharmacy for miles.

10. Monitoring

How will the implementation of the proposal be monitored and by whom?

10.1 This analysis is intended to assist Council in considering whether the changes to the standards should be approved and/or subject to further amendment before introduction.

10.2 Separately, we have identified a number of issues which will be raised with Council in due course when we present our second report on the analysis of feedback relating to the draft guidance, including:

- a. Ensure that the expectations of pharmacy professionals are set out clearly in the draft guidance, including the position on referrals;
- b. Review the language and tone of the draft guidance to ensure the rights of pharmacy professionals appropriately and adequately recognised;
- c. Expand the draft guidance for employers to help mitigate risks of discrimination or harassment against pharmacy professionals in the workplace due to their religion or belief, or perceived religion or belief;
- d. Consider writing to employers to remind them of their legal responsibilities and direct them to appropriate sources of advice and guidance;
- e. Consider including a reference to social discrimination in the guidance, specifically to reflect the needs and concerns of people in the criminal justice system;
- f. Consider whether the guidance adequately addresses safeguarding issues;
- g. Work with the Pharmacy Schools Council to ensure that changes are communicated effectively to students, and to identify what further work can be done to help students raise concerns about conflicts early in their careers; and
- h. Conduct a review of our standards and guidance should the law on euthanasia and assisted dying change in the future.

How will the results of monitoring be used to develop this proposal and its practices?

The issues identified through this analysis will be taken into account when deciding whether further changes should be made to the standards and/or guidance prior to implementation.

What is the timetable for monitoring, with dates?

The standards will be kept under continuous review, with a formal review carried out every 3 – 5 years.

The supporting guidance will be reviewed, as and when appropriate – or when there is a relevant change in the law.
Consultation on religion, personal values and beliefs

Analysis of the effects on equality
Annex A: List of one-to-one meetings

Organisations listed in alphabetical order
[Please note that a complete list of all of the organisations that responded, in writing, is included in the analysis of consultation responses]

Board of Deputies of British Jews [joint with the Jewish Medical Association]
Boots Pharmacy
British Humanist Association
British Pregnancy Advisory Service
Catholic Bishops Conference of England and Wales
Chief Pharmaceutical Officer, Scotland
Christians in Pharmacy
Christian Medical Fellowship
Community Pharmacy Scotland
Faculty of Sexual and Reproductive Health
Family Planning Association
Guild of Healthcare Pharmacists
Hindu Council UK
Jewish Medical Association
Kamsons Pharmacy / Member of the Association of Independent Multiple Pharmacies
LGBT Foundation
National Dignity Council [joint with the Race Equality Foundation]
National Pharmacy Association - Forum
National Secular Society [joint with the Secular Medical Forum]
NHS Education for Scotland
NHS England Health and Justice Commissioning
Muslim Council of Britain
Pharmacies Committee
Pharmacy Law and Ethics Association
Pharmaceutical Services Negotiating Committee
Race Equality Foundation [joint with the National Dignity Council]
Secular Medical Forum [joint with the National Secular Society]
Terrence Higgins Trust
The Christian Institute
Meeting paper
Council on Thursday, 06 April 2017

Public business
Consultation on revalidation for pharmacy professionals

Purpose
To discuss and consider a consultation document on revalidation for pharmacy professionals including a new revalidation framework.

Recommendations
The council is asked to agree for consultation our proposals on revalidation for pharmacy professionals.

1. Background

1.1. It has become a widely accepted principle that healthcare professionals, to maintain the confidence and trust of patients and the public, need to demonstrate that their knowledge and skills are current and they continue to be fit to practise.

1.2. A number of reports into high profile failures\(^1\) in healthcare, predominantly although not exclusively, involving medical practitioners led to calls from governments, patient representative bodies and others for the health professional regulators to introduce reforms to provide assurance about their registrants.

1.3. In particular the Bristol Inquiry report made extensive recommendations about the need for all healthcare professionals to be subject to some form of regulatory scrutiny and revalidation. A UK white paper published by the Department of Health (England) with UK and cross party support, *Trust, Assurance and Safety - The regulation of healthcare professionals in the 21\(^{st}\) century*\(^2\) set out governments’ expectations that all healthcare professional regulators would bring forward revalidation proposals in due course for their professions.

1.4. For some time the pharmacy professions have been required to undertake CPD and submit records to the GPhC (as well as the previous regulator the RPSGB). However, Council made an early commitment to review the process by which the pharmacy professions provided assurance to the public, through the regulator, that

\(^1\) [www.bristol-inquiry.org.uk](http://www.bristol-inquiry.org.uk); [www.shipman-inquiry.org.uk](http://www.shipman-inquiry.org.uk)

individuals remained up to date in their knowledge and competence. This was in recognition that CPD alone was not consistent with the independent reports referenced above, or would meet the expectations of policy makers, governments or our oversight body the Professional Standards Authority.

1.5. Preliminary scoping work was carried out from 2011 to 2013 including a review of relevant research and reports before Council made a commitment at its meeting in November 2013 to develop a new framework for assuring the continuing fitness to practise of pharmacists and pharmacy technicians.

1.6. Council commissioned work from the executive of the GPhC to develop a new framework which would include three core elements, described at that time as “a peer review process”, “a review of continuing professional development (CPD)” and the use of “external performance indicators”.

1.7. Proposals were developed against a set of core principles set out below.
- The primary role of continuing fitness to practise is to reaffirm registrants continue to meet the core professional regulatory standards.
- The framework will need to take account of the full range of roles and settings of pharmacy practice and as a result be based upon a common standard and flexible process and evidence requirements.
- The framework will complement and where possible incorporate existing mechanisms provided by organisations within pharmacy that support continuing fitness to practise assurance.
- Any framework would need to be appropriately tested, piloted and evaluated using robust evaluation criteria including impact assessment of intended and unintended consequences.

1.8. The work to research, test, pilot and evaluate proposals has been completed and we are now in a position to present a draft framework for revalidation for pharmacy professionals.

1.9. Appended to this paper is a draft consultation document and revalidation framework document that set out the proposals and ask for the views of the widest possible range of our stakeholders.

2. Introduction

2.1. We have undertaken a three year development programme which – in this development phase – we have referred to as “continuing fitness to practise”. We have spent a considerable period researching, testing, piloting and evaluating our proposals and they have been developed in collaboration with pharmacy organisations and pharmacy professionals themselves as well as patients and the public.

2.2. The pilot ran from April 2015 to December 2016 and over 1300 volunteers took part. Pilot participants were asked to record four CPD entries, engage in a peer discussion and provide a reflective account (case study) that related to Standard 3 of the Standards for Pharmacy Professionals.

2.3. We commissioned an independent evaluation of the pilot, undertaken by Solutions for Public Health. Having considered this report we are now in a position to share our thinking with everyone affected by the potential changes so that we can review feedback before they are implemented in 2018.

2.4. The development work has been informed by regular engagement with the sector, but particularly through the work of the Continuing Fitness to Practise Advisory Group chaired by Lord Kirkwood of Kirkhope. This group has a wide ranging membership with representatives from across Great Britain and including pharmacists and pharmacy technicians as well as a patient representative.
3. **Key considerations**

3.1. The council is asked to consider the document as a whole, but may wish to consider the following factors related to the consultation documentation to inform their discussions and debate:

3.2. One area of consistent feedback we heard from all of our stakeholders was that the terminology of continuing fitness to practise was confusing and was too readily associated with the processes we use to investigate and act upon the rare instances when concerns are raised about pharmacy professionals.

3.3. Revalidation for pharmacy professionals is our proposal for what a future framework of assurance should look like. It builds upon existing processes for continuing professional development (CPD) and adds additional components to further assure the public that their trust in pharmacy professionals is well placed. The framework encourages reflection on learning and practice and focuses on outcomes for people using pharmacy services.

3.4. Early informal feedback about the name has been positive; not least because of the clarity and parity in language with the arrangements with medicine, nursing and midwifery.

3.5. The components of the framework have been rigorously tested with stakeholders and through research, however this is the first time many of our stakeholders will learn about our proposals and the council should consider if the documents make the proposals clear enough and also make the case for introduction.

4. **Core proposals**

4.1. In future, we want to reduce and simplify the requirements we have for CPD recording. We will request fewer CPD entries (four as compared with the current nine) plus two other types of activities to be completed each year, a peer discussion as well as a reflective account. Further details about these proposed activities are set out in the consultation document and revalidation framework in the appendices to this paper.

4.2. In addition to simplification of CPD requirements and the introduction of a requirement to undertake and record both a peer discussion and reflective account, we are also proposing to:

   - simplify standards and guidance associated with CPD and revalidation
   - ask for records to be submitted each year at the same time as declarations for renewal of registration are made
   - improve the review of submitted records

4.3. Through our engagement and development phase we have heard consistent feedback about the need for us to improve experience of registrants submitting entries. We are proposing, alongside the key policy changes set out, to make some significant enhancements to our process and procedures to make the experience for our registrants, and pharmacy bodies supporting their members, more efficient and streamlined. These proposals include:

   - Producing an integrated online recording tool so that pharmacy professionals can use one system to log into their account at GPhC to record entries and renew their registration.
• Reducing the need for “dual recording” by collaborating with organisations such as professional bodies, education and training providers and employers who have their own learning and development portfolios so that records can be transferred easily into the GPhC online recording tool.
• Introducing automated support for our registrants in the online recording tool to prevent simple errors in recording leading to remedial action.
• Introducing easier ways to report and provide evidence of extenuating circumstances that might prevent submission or complete submission of records at the time of renewal.

4.4. The questions that underpin the consultation have been designed to ensure we receive feedback on each of the three key components of the proposals for revalidation for pharmacy professionals.

5. **Equality and diversity implications**

5.1. In all stages of our development work we have considered whether there are any significant equality implications, either positive or negative, for registrants or members of the public. We have engaged with a wide range of audiences and have ensured that our testing involved a sample of pharmacists and pharmacy technicians broadly reflective of the profession as a whole. We have not identified any significant negative equality or diversity implications of our proposals and expect there to be a positive benefit for patients and the public.

5.2. However we ask a specific question in the consultation and to ensure we receive feedback on any relevant issues.

5.3. Throughout the development programme a detailed draft EIA has been developed and is continually updated as new aspects of the development programme have commenced. The council’s assurance group has been given sight of a summary of the known impacts and the plans to use consultation and engagement to collect further evidence of impact.

5.4. A final EIA will be presented to Council for approval following the consultation.

6. **Communications**

6.1. A comprehensive communications plan has been produced which uses the consultation document and revalidation framework as the core communications messages. Further more detailed materials for our website, events, social media, meetings, conferences, and other communications channels will be produced following the agreement of the text of the consultation and prior to the launch of the consultation before the end of April 2017.

7. **Resource implications**

7.1. Resource implications of the development programme and of the consultation and engagement period have been factored into a number of teams’ budget and resource plans across the organisation over this and the following financial years.
8. Risk implications

8.1. A full risk register for the development programme and engagement activities has been produced and recorded within the strategy directorate’s risk register.

8.2. The risks most pertinent to the consultation and engagement phase have been mitigated by the production of a comprehensive communications plan that supports our efforts to reach out to all parties affected by the proposals. Further risks have been mitigated by the programme of research, testing, piloting and evaluation that has been done to provide an evidence base to support all of the proposals in the consultation materials.

9. Monitoring and review

9.1. The council will receive a consultation analysis report in September 2017 and, following that, a consultation response report at a later meeting on which to make decisions on if and how to proceed.

9.2. The council’s assurance group will continue to review more detailed information in advance of Council meetings to provide further assurance of the robustness of the development and consultation activities.

9.3. The advisory group will also continue to review draft information to help inform development and the consultation analysis and response documents so that council can be assured that affected parties are involved in our work.

10. Recommendations

The council is asked to agree for consultation our proposals on revalidation for pharmacy professionals.

Osama Ammar, Head of Continuing Fitness to Practise
General Pharmaceutical Council
Osama.ammar@pharmacyregulation.org
Tel 020 3713 7962

30 March 2017
Contents
About the GPhC

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacy premises in England, Scotland and Wales. It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.

We:

- promote professionalism within pharmacy
- assure the quality of pharmacy, including its safety
- support improvement in pharmacy

We have a number of ways in which we do this. These include:

- registering and listing publicly the pharmacy professionals and pharmacies that provide care to patients and the public
- setting and promoting the standards required to enter and remain on our register
- receiving assurances, in a number of ways, that pharmacy professionals and pharmacies continue to uphold our standards – and acting appropriately when they do not
- sharing with others what we learn through our work
- investigating concerns about the people or pharmacies we register and taking proportionate action to protect the public and promote our standards
The trust people have in pharmacy professionals is strong. It is based mostly on the knowledge, attitudes and behaviours of individual pharmacists and pharmacy technicians and the relationships they have with the people using their services. But part of that trust also comes from the expectation of people, particularly patients and service users, that health professionals – be they doctors, nurses or pharmacists – keep their knowledge and skills up to date. This consultation is about the changes we are proposing to enhance this process and bring forward a new model in pharmacy to support pharmacists and pharmacy technicians in keeping their knowledge and skills up to date, while at the same providing assurance to the public that they are doing so.

For some time pharmacists and pharmacy technicians have been required to undertake and record their Continuing Professional Development (CPD) activities. However, we know that if we are to provide the assurance that the public rightly expect we need to change the current requirements, to make them more effective and proportionate for pharmacy professionals. We also know that carrying our learning and taught activities in a traditional CPD model, while an important part of keeping knowledge and skills up to date, is limited. This consultation is about our proposals to enhance that model, incorporating CPD into a more effective model of assurance.

We have undertaken a three year development programme which – in this development phase – we have referred to as “continuing fitness to practise”. We have spent a considerable period researching, testing, piloting and evaluating our proposals and they have been developed in collaboration with pharmacy organisations and pharmacy professionals themselves as well as patients and the public. Now is the time to share our thinking with everyone affected by the potential changes so that we can review feedback before they are implemented in 2018.

One area of consistent feedback we heard from all of our stakeholders was that the terminology of continuing fitness to practise was confusing and was too readily associated with the processes we use to investigate and act upon the rare instances when concerns are raised about pharmacy professionals.

Revalidation for pharmacy professionals is our proposal for what a future framework of assurance should look like. It builds upon existing processes for continuing professional development (CPD) and adds additional components to further assure the public that their trust in pharmacy professionals is well placed. The framework encourages reflection on learning and practice and focuses on outcomes for people using pharmacy services.

Revalidation is something that health professionals and their employers know well from the models that have been put in place for doctors, nurses and midwives. The pharmacy professions are distinct from other professions and from one another so we are proposing something similar in name, but fundamentally different in design so that it is tailored for pharmacy.

We are seeking views from members of the public, patient representative organisations, pharmacy professionals, professional leadership organisations, unions, employers, funding bodies for health and social care, education and training providers and funding bodies, governments, regulators and others to help inform our approach and we look forward to hearing your views.
Overview

The GPhC is consulting until 17 July 2017 on proposals for revalidation for pharmacy professionals. You can find out more detail about the proposals (summarised in this document) on our website: INSERT WEBSITE LINK HERE

We are making changes to the way we work with pharmacy professionals to provide further assurance that trust in pharmacy professionals is well placed. Pharmacy professionals already do things to provide that assurance but we believe it can be enhanced and improvements can be made for the benefit of the people using pharmacy services and pharmacy professionals.

At the moment pharmacy professionals make declarations every year that they meet our standards and remain fit to practise as part of their yearly renewal of their registration with us and they record CPD activities and submit those records to us upon request so that we can review them.

In future, we want to reduce and simplify the requirements we have for CPD recording. We will request fewer CPD entries (four as compared with the current nine) plus two other types of activities to be completed each year. As a summary our proposals for what pharmacy professionals must do each year are:

- Make declarations that they continue to meet our standards and remain fit to practise
- Undertake, record and submit four CPD activities
- Undertake, record and submit a peer discussion
- Undertake, record and submit a reflective account against one of our standards for pharmacy professionals

Over almost three years of research, testing, piloting and evaluation we have gathered evidence to show that this approach will be more engaging and meaningful to pharmacy professionals and give a greater sense of assurance to the people using pharmacy services.

This consultation document has two sections:

**What we are changing and why**: this explains what we currently do and propose to do; it sets out what we have taken into account when considering proposing the change; and it explains why we want to make changes.

**The work we did to reach our proposals**: this explains in summary the ways that we went about considering how to change, measuring the impact of the proposals, and gathering evidence to support them.
The consultation process

We have considered a range of information in developing this consultation, in particular the evidence we have collected over the course of our research, testing, piloting and evaluation [INSERT WEBLINK]. We now want to communicate our proposals and receive feedback to make sure our new approach meets the expectations of the people using pharmacy services and pharmacy professionals. Please let us know what you think about the proposals described in this document.

The consultation will run for 12 weeks and will close on 17 July 2017. During this time we welcome feedback from individuals and organisations. We will send this document to a range of stakeholder organisations, including professional representative bodies, employers, education and training providers, and patients’ representative bodies.

We hope you will read this consultation and consider responding. You can get more copies of this document on our website www.pharmacyregulation.org/get-involved/consultations/active-consultations or you can contact us if you would like a copy of the document in another format (for example, in a larger font or in a different language).

How to respond

You can respond to this consultation in a number of different ways. You can fill in the questionnaire at the end of this document or go to: www.pharmacyregulation.org/get-involved/consultations/active-consultations and fill in an online version there.

If you fill in the questionnaire in this document, please send it to:

- consultations@pharmacyregulation.org with the subject ‘Revalidation for pharmacy professionals’ or post it to us at:
- Revalidation for pharmacy professionals consultation response
  Revalidation team
  General Pharmaceutical Council
  25 Canada Square
  London E14 5LQ

Comments on the consultation process itself

If you have concerns or comments about the consultation process itself, please send them to:

- feedback@pharmacyregulation.org or post it to us at:
- Governance Team
  General Pharmaceutical Council
  25 Canada Square
  London E14 5LQ

Please do not send consultation responses to this address.
Our report on this consultation

Once the consultation period ends, we will analyse the responses we receive. The council will receive the analysis report at its meeting in September 2017. We will take what we have heard and the council’s views into account when producing a consultation response report. The council will receive this document at a later date when they will decide if and how to proceed in 2018.

We will also publish both reports so that there are summaries of the responses we received and an explanation of the decisions taken. You will be able to see this on our website www.pharmacyregulation.org
What we are changing and why

The changes we are proposing are set out in the revalidation framework document which accompanies this consultation. The revalidation framework sets out the expectations on pharmacy professionals and describes the processes we will follow to provide assurance that the trust in pharmacy professionals is well placed.

We are changing a number of things about how we work and what we are asking pharmacy professionals to do. The section below outlines the changes in summary form. The table on the following pages set out the changes and what they mean in more detail. You can find out even more detail on our website: [INSERT WEBLINK]

The changes we are proposing are to:

- Reduce and simplify the recording requirements for CPD
- Introduce a peer discussion
- Introduce a reflective account
- Simplify the standards and guidance
- Ask for records to be submitted each year at the same time as declarations for renewal of registration are made
- Improve the review of submitted records

As well as making these changes upon which we are consulting, we also plan to make some changes to how we work which will make the process of recording and submitting records to us easier. These include:

- Producing an integrated online recording tool so that pharmacy professionals can use one system to log into their account at GPhC to record entries and renew their registration.
- Reducing the need for “dual recording” by collaborating with organisations such as professional bodies, education and training providers and employers who have their own learning and development portfolios so that records can be transferred easily into the GPhC online recording tool.
- Introducing automated support for our registrants in the online recording tool to prevent simple errors in recording leading to remedial action.
- Introducing easier ways to report and provide evidence of extenuating circumstances that might prevent submission or complete submission of records at the time of renewal.

We want to introduce change in a phased way so that the pharmacy sector has time to adapt. We plan to consult and consider what we hear over the remainder of 2017.

In 2018 we will begin implementation by communicating and engaging with all those affected about any changes that we make. We will ask pharmacy professionals to begin using our new approach in 2018, but we will not plan to review records until 2019 for revised CPD records and 2020 for peer discussion and reflective account records and give lots of notice before any renewal deadlines where submission of records will be required.
<table>
<thead>
<tr>
<th>Proposed change</th>
<th>What the change means</th>
<th>Why the change is necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce and simplify the recording requirements for CPD</td>
<td>At the moment, we ask pharmacy professionals to record nine CPD entries each year. We also ask for lots of information to be provided for each entry. We want people to focus on the benefit the learning and development activity has on the people using a pharmacy professional’s services by reducing the number of CPD entries each year to four and using a simplified recording process.</td>
<td>We know that our current requirements are perceived as being time consuming and not always of benefit to pharmacy professionals or the people using their services. Therefore, we want to make the exercise of recording entries more accessible and focused on the things that matter to pharmacy professionals and the people using their services. We also want to make time available for pharmacy professionals to undertake the peer discussion and reflective account by reducing the amount of time spent recording CPD entries.</td>
</tr>
<tr>
<td>Introduce a peer discussion</td>
<td>We want pharmacy professionals to identify someone with whom they will speak about their practice and record the benefit it has for the people using their services. Importantly we want the relationship to be trusted, respected, open and honest, and feel like a safe space where learning can arise from things that have gone well and not so well. It will require some additional time to undertake a peer discussion but we anticipate that once relationships are formed the time it will take will reduce each year. If someone is selected for review, we would only seek to confirm that the peer discussion took place and not ask for details of what was discussed.</td>
<td>We have evidence to show a peer discussion is a valuable exercise for driving improvement and reflection. We also see this as being an important way to reduce the sense of professional isolation that many pharmacy professionals have reported to us. We also know that members of the public think it is important that other people are involved in the process of reflection to give them further assurance that an objective perspective is brought in to enhance learning and development.</td>
</tr>
<tr>
<td>Proposed change</td>
<td>What the change means</td>
<td>Why the change is necessary</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Introduce a reflective account (in piloting we called this a case study but learning from evaluation suggested this was confusing to some pharmacy professionals so we have renamed it)</td>
<td>We want pharmacy professionals to write a reflective account based on our standards for pharmacy professionals. We think that pharmacy professionals are reflecting upon the standards continuously, but this exercise will help demonstrate that it is happening. We also know from our testing that we will need to provide supporting guidance and examples as this is an exercise that some of them have not done before as part of their initial education and training.</td>
<td>We want our approach to revalidation to return pharmacy professionals to the core standards that underpin their practice in whichever form it may take. Therefore, we want the framework to explicitly embody those standards, though they are woven throughout.</td>
</tr>
<tr>
<td>Simplify the standards and guidance</td>
<td>We currently have a complex arrangement of standards, guidance and legislation underpinning our CPD requirements. We want to use a single set of standards (the standards for pharmacy professionals) and a single set of more detailed guidance and requirements (the revalidation framework).</td>
<td>The complicated approach we currently have makes it harder to communicate our expectations and for them to be understood. Simplification will mean it will be easier to understand the expectations that we have on pharmacy professionals.</td>
</tr>
<tr>
<td>Proposed change</td>
<td>What the change means</td>
<td>Why the change is necessary</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Ask for records to be submitted each year at the same time as declarations for renewal of registration are made</td>
<td>We want all our registrants to submit their records to us at the time they renew their registration with us. We will then select randomly and in a targeted way which of our registrants’ records we will review. The process of linking submission to renewal may mean that some pharmacy professionals are entered into a process of remediation if they fail to submit some or all of their records (without good reason) on time. The process of remediation will include interventions from us and a requirement for records to be submitted. In rare cases, following remediation we may decide a process of administrative removal. If there are legitimate reasons for non-submission or incomplete submission, such as illness or periods of maternity leave, we will continue to accept these and registration will not be at risk.</td>
<td>Our current expectation is that records are made annually, but our previous approach to reviewing records left some under the impression that we only expected records to be made when they were called for review. This approach makes our expectation clearer. We have already introduced random and targeted selection for review of records as a result of our consultation in 2016. By asking all our registrants to submit each year we can provide further assurance that the activities are being completed and we can also select from the records submitted each month the ones that will be reviewed. We also believe that by asking for records to be submitted each year we can spread the burden placed on pharmacy professionals more evenly than is the case for some, who undertook their CPD continuously but only recorded all their entries when we asked to review them.</td>
</tr>
<tr>
<td>Proposed change</td>
<td>What the change means</td>
<td>Why the change is necessary</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Improve the review of submitted records</td>
<td>We want to improve criteria for review of records and provide a clearer framework for us to offer developmental feedback to pharmacy professionals. We want our reviewers to be more consistently matched to the records they review: pharmacist reviewers for pharmacist submissions and pharmacy technicians for pharmacy technician submissions. We want to pair a pharmacy professional reviewer with a lay reviewer to enhance the voice of patients and the public in the process and also to assist with ensuring quality of the review process. We want to offer better quality feedback to the pharmacy professionals who are selected for review. And we also want to share learning from the feedback with all pharmacy professionals so that everyone can continue to develop and improve.</td>
<td>We have listened to feedback that our review criteria are not effective in ensuring that pharmacy professionals record reflections on their learning and practice. We also accept that the input based requirements often mean that the feedback provided by reviewers lacks value and is often perceived to be unhelpful. Now that we are using a sampling approach, we can produce more developmental and tailored feedback for the pharmacy professionals selected for audit. We can then share the learning to continue to support improvement for all pharmacy professionals. At the moment our review process involves single reviewers, who may not be familiar with the context in which a pharmacy professional practices. We think it is more robust when a balanced view is taken involving both a professional and a lay person working together.</td>
</tr>
</tbody>
</table>
The work we did to reach our proposals

The development of these proposals began shortly after our establishment as the regulator for pharmacists, pharmacy technicians and registered pharmacies in 2010. This included reviewing work undertaken by the previous regulator, the RPSGB, as well working with other regulatory bodies, including the General Medical Council to consider learning from others.

After almost three years (2014-2017) of research, testing, piloting and evaluation activities we have evidence to show our proposals are the right ones for us to consult upon. This section of the document outlines the steps we have taken to reach our proposals, including how we involved pharmacy professionals, their representatives and members of the public. You can find more detail in reports that we and others have produced about this work on our website: [INSERT WEBSITE LINK]

The advisory group

The advisory group established in 2014 is chaired by Lord Kirkwood of Kirkhope and made up of representatives from more than thirty organisations. The purpose of the group was to advise and provide feedback on the development work and also on the proposals. The group included representatives of pharmacy professionals and a patient representative and worked collaboratively through regular workshops to steer all facets of the work that has been undertaken. The advisory group was critical to the development of the proposals and their insights have significantly altered the proposals over the course of the development programme.

Research

Before and during 2015 we undertook a variety of forms of research including commission studies and desk research to understand more about:

- The outcomes we are trying to achieve;
- how others healthcare regulators were working;
- theory and practice underpinning activities like peer discussion; and
- how our current approach to CPD was perceived by pharmacy professionals and our reviewers.

Testing

After our research in 2015 we used the evidence we collected to test the proposals with more than 200 pharmacy professionals from a range of roles and contexts of pharmacy practice. We evaluated the results and found that the proposals were largely effective, but that we had more work to do to make our expectations clearer and provide support to pharmacy professionals. That learning was applied to the development of our pilot.

Piloting

In 2016 we commenced a pilot with over 1300 volunteers from a range of roles and contexts of pharmacy practice. Over eight months the volunteers used draft guidance and examples we produced to complete entries for revised CPD recording, a peer discussion and an early version of the reflective account. During the pilot we engaged with volunteers using an online workshop to find out which parts of the pilot were working for them, which could be changed and their proposals for improvements. Their feedback was used to improve the proposals that are made in this consultation.

Evaluation

During and after the pilot in 2016, Solutions for Public Health (SPH) conducted an independent evaluation of the pilot. SPH began their work by reviewing the outcomes we were aiming to achieve and designed an evaluation approach based on these. Through a range of methods, SPH collected data about how pharmacy professionals participated and perceived the pilot arrangements. In their independent report, SPH found that the proposals largely had their anticipated impacts and in some cases some especially positive outcomes. There were areas for
improvement in the design of the proposals and these have been incorporated into the proposals made in this consultation.

**Equality and diversity**

In all stages of our development work we have considered whether there are any significant equality implications, either positive or negative, for registrants or members of the public. We have engaged with a wide range of audiences and have ensured that our testing involved a sample of pharmacists and pharmacy technicians broadly reflective of the profession as a whole. We have not identified any significant negative equality or diversity implications of our proposals and expect there to be a positive benefit for patients and the public. However we ask a specific question in the consultation and would welcome any feedback to ensure we are considering any relevant issues.
Introduction

The General Pharmaceutical Council (GPhC) is the independent regulator for pharmacists, pharmacy technicians and registered pharmacies in England, Scotland and Wales.

The trust people have in pharmacy professionals is strong. It is based mostly on the knowledge, attitudes and behaviours of individual pharmacists and pharmacy technicians and the relationships they have with the people using their services. But part of that trust comes from the expectations that people have on how the professions work in collaboration with us to provide assurances that pharmacy is safe and effective.

Revalidation for pharmacy professionals is one of the ways that we work with pharmacy professionals to provide assurance that the trust in pharmacy professionals is well placed. It builds upon the work that pharmacy professionals do as part of their work and development to ensure they remain fit to practise through the use, maintenance and development of professional knowledge, attitudes and behaviours.

Revalidation is a term that health professionals and their employers know well from the models that have been put in place for doctors, nurses and midwives. The pharmacy professions are distinct from other professions and from one another so the framework for pharmacy professionals is similar in name, but fundamentally different in design so that it suits pharmacy.

Pharmacy professionals for a long time have provided assurance of their ability to keep their knowledge and skills up to date by undertaking and recording learning and development activities. But in the evolving world of healthcare, patients and the public would like to have further assurance that pharmacy professionals remain safe and effective beyond initial registration. The framework encourages reflection on learning and practice and focuses on the outcomes the people using the services of pharmacy professionals to provide that assurance.
**About the language in this document**

Throughout this document, ‘we’ or ‘our’ refers to the GPhC and ‘you’ or ‘your’ refers to pharmacists and pharmacy technicians.

‘Reflective practice’ is a term with many definitions. For the purposes of revalidation we have chosen to use this definition: ‘the critical evaluation of practice and learning to find ways to benefit further the people using your services’.

Pharmacy professionals work in many different places and provide their services to a variety of people (not just those who might be defined as patients). Therefore, we have chosen to use the words ‘**people using your services**’ to refer to any person receiving services from a pharmacist or pharmacy technician. The term is inclusive so that it is relevant to all pharmacy professionals whether they directly interact with patients or not. The term includes, but is not limited to:

- patients,
- family and carers of patients,
- health professional colleagues,
- non-health professional colleagues,
- students or trainees, and
- organisations.
**About the revalidation framework**

The revalidation framework describes how pharmacy professionals, together with the GPhC, provide further assurance to the public that their trust in pharmacy professionals is well placed.

One of our standards for pharmacy professionals states that you must maintain, develop and use your professional knowledge and skills. The revalidation framework is one of the tools we use to demonstrate to members of the public that this standard is met by you and other pharmacy professionals.

The revalidation framework sets out the expectations of what you must do each year:

- your records: recorded CPD, a peer discussion and a written reflective account
- submitting records to us and what happens when they are not or cannot be submitted

It also covers what we will do, including:

- selecting records for review
- reviewing records and providing feedback to you
- following up when it seems our review criteria are not met
The process explained: overview

You undertake and record activities throughout the year on our online portal or in a format approved by us.

At the point of registration renewal you make a number of declarations including that you meet the requirements for revalidation.

You submit records to us before your renewal deadline

If you are unable to submit some or all of your records for a good reason you can tell us in advance of the renewal deadline and depending on your circumstances you may still renew (it is better to tell us about these reasons before submission).

If you have not submitted some or all of your entries without good reason you will be given another opportunity (called remediation) to submit.

Once your records are submitted they may be selected for review. The selection process may be random or targeted.

If your records are selected for review, we will let you know and tell you how long it will take before you know the outcome.

Your records will be reviewed against the review criteria, jointly by a pharmacy professional and a lay reviewer.

If your records meet our review criteria we will tell you and give you feedback.

If your records do not meet our review criteria we will tell you, give you feedback and provide another opportunity to submit (via remediation)

In all cases we will maintain a record of the outcome of the review and the date it was completed.

Remediation

Our remediation process provides an opportunity for you to send us records that meet our review criteria.

In very rare cases, following remediation we may decide to start a process of administrative removal where you have 28 days to submit or make representations to us as to why you have not sent us some or all of your records. As part of your representations you may request an extension and explain the reasons why, and how long you need to submit.

If you do not make representations or submit within 28 days, a Notice of Removal letter will be issued and you will have 28 days to request an appeal with the Appeals Committee.

If you are unable to submit some of your records without good reason, you will be given another opportunity to submit. If following this step we still do not receive all your records we will initiate administrative removal.

If you are unable to submit all of your records without good reason, we will start the process of administrative removal.

If you have submitted all your records by your renewal deadline but they do not meet our review criteria we will give you another opportunity to submit. If upon your second attempt your records still do not meet our review criteria we will start the process of administrative removal.
The process explained: recording

This section of the framework describes what you must do and record each year that you are registered as a pharmacy professional. You can find information about:

- what you are expected to do
- how to record
- CPD
- peer discussion
- the reflective account

You can find out more about the structure of records and supporting guidance in Appendix 1.

We have also produced example entries to help you understand what good records looks like. These have been provided as a separate document and are also available on our website [link to be added].

What you are expected to do

Each year, and by the time you renew your registration, you are expected to:

- Undertake, record and submit four CPD entries per year, of which a minimum of two must be planned learning activities
- Undertake, record and submit one peer discussion per year
- Undertake, record and submit one reflective account per year.

How to record

Below is much more detail about how to undertake and record CPD, a peer discussion and a reflective account. However there are some common things to all types of record:

- Before submission you can keep records in our online portal but you might want to keep your records somewhere else (in written notes or another online portfolio for example)
- At the point of submission, your records are expected to be in our online portal. You may therefore need to take steps to transfer your records to us before your registration renewal deadline
- We do not normally accept paper submissions. If you have circumstances which prevent you from using our online portal please contact us.
- Your records must be relevant to the safe and effective practice of pharmacy and should relate to the context of your practice including any specialisms
- Your entries should demonstrate our review criteria (see section X of this document). The guidance we have produced reflects these criteria so you will find it helpful to refer to that as well.
- Your entries should relate to activities that you have completed, with examples of the benefit you think they have made for the people using your services.
- Your records should be your own.
- You should respect patient confidentiality.
CPD

Research demonstrates that a simple approach to CPD recording encourages reflective practice. We want you to complete four CPD entries a year of which a minimum of two must be planned.

There are two types of learning that you can record in your CPD entries:

- **Planned learning** – when you decide to develop your knowledge and or skills in advance of undertaking a learning activity.

- **Unplanned learning** – when an event occurs that causes an unscheduled learning activity without prior thought or planning, for example through reading a journal or talking to a colleague.

These types of learning can feed into one another. A planned learning activity might lead to an unplanned one or the other way round. Although patients and the public have told us that they prefer to see planned learning activities to provide them with assurance that learning and development is taking place, we have included the option to record both planned and unplanned learning because pharmacy professionals have told us that they find both approaches useful.

You should continue to undertake as much CPD as is necessary for you to be able to practise safely and effectively but for the purposes of submission we only want to see entries that have relevance to the people using your services.

We ask that you give a real example of how the learning has **benefited** the people using your services. We want to hear about the benefits for the people using your services (while respecting patient confidentiality) using real rather than hypothetical examples. In some cases, recording may involve more than one stage where you start an entry and then return to it later after the learning has been applied.

Across your four entries you should attempt to learn using a variety of methods. We want to see the relevance and breadth of your learning and development activities and the methods you use should be varied depending on what you are learning.

Your learning should also reflect the context of your practice. If you have multiple roles or specialisations, you should use your four entries to reflect that breadth.

**Peer discussion**

Peer discussion is a learning and development activity that encourages you to engage with others in your reflection on learning and practice. Research indicates that having an external view can help pharmacy professionals to reflect on their practice and can also reduce the potential for professional isolation. To be most effective, these discussions should be formative, open and honest and with someone who you trust and respect.

For your peer discussion to be effective you need to consider the following things:

- locating an appropriate peer or peers
- sharing relevant information to guide the discussion
- undertaking and responding to the discussion in a reflective way
There are different types of peer discussion and only you will be able to determine which type would be most effective for you. Some types of peer we have seen to be effective in prompting discussion are:

- a trusted colleague
- a line manager to staff member (or the other way round)
- another healthcare professional
- a group of peers
- a mentor or coach

For many of you the most effective peer relationship would be with another pharmacy professional. However, for some of you, it may be appropriate to consider a peer from another health profession or possibly someone who is not a health professional but has insight into the kind of work that you do, for example, some pharmacy leaders may consider seeking out someone in another leadership role who is not a pharmacist. There may be rare occasions where you choose to have a discussion with an “expert patient”\(^1\) with a long term condition. You may also have different peers at different stages of your career.

Your peer should be someone who understands aspects of the work that you do and someone that you respect and can trust. This might mean it is an individual you work with, or a group of people with similar roles to you, someone with the same or similar professional background, or a colleague from a multidisciplinary team. The relative status of the peer does not matter in terms of prompting discussion and you may choose a peer who has a different level of authority to you.

Choosing a peer is important and you should think about perceptions in terms of independence and objectivity. We would strongly recommend that you do not choose anyone with whom you have too close a relationship as a peer, such as a family member or very close friend.

You might find your peer(s) through:

- your employer
- an education and training provider
- a professional body or association
- local or national networks

Before your peer discussion you should consider sharing information to make sure the conversation is effective. You should consider discussing your CPD activities and your reflective account (particularly if you have yet to decide what they might be). You might also want to discuss other pieces of information about your practice, such as:

- quality improvement activity
- critical incidents
- significant events
- review of complaints and compliments
- feedback you receive from the people using your services
- performance and development reviews
- the standards for pharmacy professionals

The discussion should be formative in terms of how it influences your development (your peer is not making an assessment of you). You are not required to send us information on the subjects discussed. The discussion is

\(^1\) The term “expert patient” is generally used when referring to patients, particularly those with long terms conditions who, working with relevant health professionals choose and are able to take more control of their treatment plan
intended to aid your reflection so your peer may ask you questions about you and your practice to help draw out reflections you might not have reached on your own. The discussion may take place face to face, via the telephone or other electronic media.

We know some peer discussions happen spontaneously rather than being pre-planned and work well. However, these are generally less effective as a reflective exercise as preparation, including thinking about the discussion in advance, will make the discussion more effective.

You should ensure your peer has agreed to be named in the record of your discussion. If you are selected for review, we will contact your peer to confirm the discussion has taken place. We will not ask your peer for any information about the discussion other than to confirm that it has happened.

If your peer discussion does not go well you can choose a different peer. In some very rare circumstances it might be the case that discussions cause concern about someone’s fitness to practise. You and your peer should refer to our guidance on raising concerns if this happens.

We have separate guidance for peers to let them know what to expect. [to be produced following consultation]

Reflective account

The purpose of the reflective account is to encourage you to think about how the work you do as a pharmacy professional relates to our standards for pharmacy professionals. Evidence suggests that producing a reflective account that focuses on how you meet our standards increases awareness and understanding of the standards and helps towards reflecting on how practice affects the people using your services.

The main parts of your reflective account will be:

- a brief summary of your practice history for the last year including who the typical users of your service may be
- a statement of how you have met one or more of our standards for pharmacy professionals
- examples to support your statement. Each year we will state which of the standards for pharmacy professionals we expect you to reflect upon.

We want you tell us briefly about your work (setting of practice, main roles and responsibilities, typical users of service) as this type of contextual information is helpful if your record is selected for review and also as a means for you to consider if the people using your services have changed.

We want you to provide at least one (but ideally more) examples to support your account so that we can see how you have reflected on the standards and their application in practice.

You may find it helpful to discuss what to include in your reflective account as part of your peer discussion.

Our frequently asked questions provide further information [link to be added].
The process explained: submission

This section of the framework describes how you submit records to us at the point of registration renewal. You can find out about:

- what happens at the time of registration renewal and what you must do
- what to do if you cannot submit all or some of your records
- what happens if you do not submit all or some of your records without a good reason

What happens at the time of registration renewal and what you must do

Each year, as part of the renewal of your registration, you are expected to submit records of your CPD, peer discussion and reflective account to us.

We will tell you when your registration renewal deadline is approaching with plenty of notice so that you have time to prepare. If you have been keeping your records in our online portal you will need to login and as part of the renewal process you will be able to submit your records to us. If you have been keeping your records somewhere else (in paper form or in another online portfolio) you will need to take steps to transfer your records into our online portal.

We do not normally accept paper submissions, but if you have reasons that prevent you from submitting online you can contact us to discuss what to do.

What to do if you cannot submit some or all of your records with good reason

There are sometimes reasons why you will not be able to submit some or all of your records at the point of registration renewal. This might happen for reasons such as sick leave, maternity leave, military postings, breaks from practice and possibly other reasons. Normally, if you have good reason, it will still be possible to renew your registration without submitting your records to us.

In some cases, it might be appropriate to accept the records that you can complete. If there are gaps in your records like this, they should not normally exceed 12 months.

In other cases, it might be appropriate to give you an extension so that you can submit all your records at a later date.

What happens if you do not submit some or all of your records without good reason

If you are unable to submit your records without good reason we will enter you into a process of remediation which will include intervention from us and a requirement for your records to be submitted.

If you still do not submit your records after the period of remediation, we will commence a process called administrative removal, described in our rules. If you are removed from the register through this process, and you later reapply for registration, we will expect to receive and review your CPD, peer discussion and reflective account records as part of your reapplication.

---

2 The General Pharmaceutical Council (Continuing Professional Development and Consequential Amendments Rules) Order of Council 2011
The process explained: review and feedback

This section of the framework describes how we review your records. You can find out about:

- the selection process
- the way we conduct reviews and what happens following a review
- the criteria we use for reviewing records and
- how we provide feedback to you if you have been selected for review.

The selection process

Once your records are submitted they may be selected for review. Our selection process includes both random and targeted elements. We will let you know if your records are selected and tell you how long it will take before you know the outcome.

We may select your records for review at any time after they have been submitted. If your records are selected for review we will notify you in advance and review the four CPD entries, peer discussion and reflective account you submitted as part of your most recent renewal. We will select a random sample of registrants to have their records reviewed each year. If your records are selected for review and you meet the review criteria we will not review your submitted records again for the next two years. In some cases you may be selected to have your records reviewed more frequently than this, for example if you have been required previously to undertake remedial measures following a review of your records, if you have a history of poor compliance with any of our standards, or if your records are submitted late and without good reason.

We may also ask you to undertake additional activities, make records of these and review your records if any the following circumstances apply to you:

- if the outcome of your review is that you have not met our review criteria
- your register entry has been restored following a period of removal and your application for restoration to the Register has been granted subject to you agreeing to comply with additional learning requirements;
- a direction has been given by Fitness to Practise Committee (following a hearing) that your continued registration is conditional on you undertaking additional learning activities.

The way we conduct reviews and what happens following review

If your records are selected they will be reviewed against our review criteria (which are outlined below and upon which our guidance is based). We will also seek to contact your peer to confirm that your peer discussion took place. We will not ask for details of the discussion, simply confirmation that it happened.

The review process will be undertaken jointly by a pharmacy professional and a lay reviewer. The two reviewers will work together to make a joint review of your records using the review criteria and produce a feedback report. The professional and lay reviewers will both be trained to undertake reviews and offer developmental feedback.

We think it is important that there are two reviewers so that one understands your practice and one who can look at your submission from a lay or patient perspective. Also, pairing reviewers improves the quality and consistency of reviews. We will also take further steps to quality assure reports to ensure consistency of quality and approach.
As part of the review of your records we may ask you to provide more information to enable us to verify that the information submitted relates to learning you have undertaken and to your context of practice.

If you meet the review criteria you will be informed and you will be provided with a feedback report to help you with your future recording. Normally after that point, you will not be selected for review for another two renewal cycles. At which point you may be selected randomly in the following years.

If you do not meet some of the review criteria you may be entered into a period of remediation where you have another opportunity to submit records.

If you do not meet some of the review criteria a second time we will follow the steps outlined in our statutory rules. These rules set out the procedures we will follow if you have not met the requirements of this framework. In very rare cases we may take steps to administratively remove you from the register or remove an annotation to your register entry relating to a speciality.

**The criteria we use to review records**

There are two types of criteria (core and feedback) that we will use to review your record. The first set of criteria, if not met, may lead to remedial measures where you are asked to submit more or revised records. The second set of criteria will be used to offer developmental feedback for your future records and we may choose to review your records again at your next registration renewal.

The following are core criteria. If the following criteria are not met we may enter you into a process of remediation:

- Records have been submitted to the GPhC in the time specified by the Registrar.
- Records are legible and have been structured in a format published or approved by the GPhC.
- Records cover the annual registration period, or, where there are gaps in records, an adequate explanation has been provided.
- There are six records (four CPD entries, a peer discussion and a reflective account) completed for each annual registration period which are relevant to the safe and effective practice of pharmacy within the individual’s context of practice, including any specialisations and the environment in which the individual practises. At least two of the four CPD entries completed for each full year are planned learning activities.
- Records comply with or safeguard patient confidentiality.\(^3\)
- Records adequately reflect any special conditions that have been placed on your practice by the GPhC, for example by the Fitness to Practise Committee or by the Registrar if your registration has been restored following removal.
- Records only contain true and accurate information\(^4\).

The following are feedback criteria. If the following criteria are not demonstrated we will offer developmental feedback for your future records and we may choose to review your records again in the following years.

---

\(^3\) If we have grounds for thinking your record breaches patient confidentiality, we will commence an investigation and may deal with this under our fitness to practise procedures. This could result in administrative removal.

\(^4\) If we have grounds for thinking your record contains false or misleading information, we will commence an investigation and may deal with this under our fitness to practise procedures. This could result in administrative removal.
Feedback criteria for planned CPD learning

There is a description of:

- what you want to learn.
- the relevance of the learning to your practice.
- how the learning will affect the people using your services.
- the options(s)/activities that have been selected to be undertaken.
- how the learning has been applied.
- how the learning following application has benefited the people using your services, illustrated with an example.

Feedback criteria for unplanned CPD learning

There is a description of:

- the activity you took part in that enabled new learning.
- what you have learnt.
- how the learning has been applied.
- how the learning following application has benefited the people using your services, illustrated with an example.

Feedback criteria for peer discussion

There is a description of:

- why you chose your peer(s)
- how the process of peer discussion has benefited your practice
- how the process of peer discussion has benefited the people using your services, illustrated with an example.

Feedback criteria for reflective account

There is a description of:

- your area(s) of practice
- the typical users of the service(s) you provide
- how you meet one or more of the standards for pharmacy professionals, illustrated with real example(s).
Visiting practitioners (registered in parts 4 and 5 of our register)

If you are registered with us on a temporary basis because you are registered as a pharmacist or pharmacy technician in another European state where you normally practise then we are able to take account of any continuing professional development that you are required to undertake in your home state.

Dual registrants

If you are registered as both a pharmacist and pharmacy technician you need to complete records that reflect the full breadth of your practice (including both pharmacist and pharmacy technician practice). However, you only need to submit your six records once a year at the time of your renewal as a pharmacist.
Data protection and confidentiality

Our use of your personal data: the GPhC’s data protection statement:

The GPhC is a data controller registered with the Information Commissioner’s Office. The GPhC makes use of personal data to support its work as the regulatory body for pharmacists, pharmacy technicians and registered pharmacies in Great Britain. Data may be shared with third parties in pursuance of the GPhC’s statutory aims, objectives, powers and responsibilities under the Pharmacy Order 2010, the rules made under the Order and other legislation. Personal data may be processed for purposes including (but not limited to) updating the register, administering and maintaining registration, processing complaints, compiling statistics and keeping stakeholders updated with information about the GPhC. Information may be passed to organisations with a legitimate interest including universities and research institutions. Please note that the GPhC will not share your personal data on a commercial basis with any third party.

Patient confidentiality

Pharmacy professionals have a duty by law and under the GPhC’s standards for pharmacy professionals not to disclose confidential information about patients without their consent unless required to do so by the law or in exceptional circumstances. Please take care when you are referring to issues concerning specific patients within a record to make the information anonymous or to use coded information.
Appendix 1

Guidance on how to complete forms

CPD planned learning form and guidance

1. What are you planning to learn?

Tell us what learning you are planning to undertake. What you need to learn may be new knowledge, skill(s), or a new attitude or approach - anything which you think will make you better able to do your job as a pharmacy professional or prepare you for a new service or role. You should be as specific as possible.

You should explain why this learning is relevant to you in your role as a pharmacy professional and how it will affect the people using your services. If you don’t think it is relevant or will not have a significant beneficial impact on anyone, you might want to consider why you are undertaking and recording this learning.

Please take care not to disclose any confidential information about patients without their consent.

2. How are you planning to learn it?

It is important for you to consider a range of options for achieving your learning across the breadth of your CPD entries. Focus your planned CPD on those activities that are relevant / likely to have the biggest impact on the people using your services.

3. Give an example of how this learning has benefited the people using your services.

Putting learning into practice is a good way to prove that you have actually learnt what you intended. Tell us what specific skill, attitudes and / or behaviours you have gained as a result of your learning.

Include a real example of how the people using your services have benefited from your learning. If you were able to introduce a new service successfully, the benefits will be clear. If you are more confident in your ability to respond to a particular query or have some new knowledge that you can use in your practice that is also a beneficial outcome.

Do include any feedback about your practice that you have had from other people.
CPD unplanned learning form and guidance

1. Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.

   Tell us about the event or activity. Be specific about the event or activity you describe. If you read an article give it a reference.

   Tell us what you learnt from the event or activity in terms of the skills, knowledge, attitudes and/or behaviours you have adopted.

   Please take care not to disclose any confidential information about patients without their consent.

2. Give an example of how this learning benefited the people using your services.

   Include a real example of how the people using your services have benefited from your learning. If you are able to introduce a new service successfully, the benefits will be clear. If you are more confident in your ability to respond to a particular query or have some new knowledge that you can use in your practice that is also a beneficial outcome.

   Do include any feedback about your practice that you have had from other people.
Peer discussion form and guidance

1. Please provide the name, contact details and the role of your peer on this occasion.

<table>
<thead>
<tr>
<th>Name of peer:*</th>
<th>Peer’s role:</th>
<th>Name of peer’s organisation:</th>
<th>Peer’s contact number:</th>
<th>Peer’s contact email:</th>
</tr>
</thead>
</table>

*If you participated in a group peer discussion, please only provide the name of one person from the group.

2. Describe how this peer discussion changed your practice for the benefit of the people using your services.

Tell us why you chose this peer.

Tell us how this peer discussion has helped you to reflect on and make improvements to your practice.

Give a real example of any beneficial outcomes for the people using your services as a result of making changes to your practice.

Do include any feedback about your practice that you have had from other people.

You are not required to include information on the subject(s) discussed if you feel the contents are confidential.
Reflective account form and guidance

1. Provide us with a reflective account of how you met one or more of the Standards for Pharmacy Professionals. [we will tell you which standard(s) each year].

Tell us briefly about your area of work (setting of practice and main roles)

Tell us briefly who the typical users of your service(s) are.

Tell us how you meet one or (ideally) more of the standards for pharmacy professionals. You may find it helpful to look at all the standards and select those that are most pertinent to your day to day activities.

Give real example(s) taken from your practice to illustrate how you meet the standards.
How we will use your responses

Following the consultation, we will publish a report summarising what we heard. We may quote parts of your response in that report or in other documents but if you respond as a private individual, we will not use your name unless you give consent for us to do so.

We may publish your response in full unless you tell us otherwise. If you want your response to remain confidential, you should explain why you believe the information you have given is confidential. However, we cannot guarantee that confidentiality can be maintained in all circumstances.

The GPhC may need to disclose information under access to information legislation (usually the Freedom of Information Act 2000).

If your response is covered by an automatic confidentiality disclaimer generated by your IT system, this will not in itself, be binding on the GPhC.

Any diversity monitoring information you give us will be used to review the effectiveness of our consultation process. It will not be part of a published response.
Consultation response form

Response to the consultation on revalidation for pharmacy professionals

For organisations

If you want any part of your response to stay confidential, please explain why you think the information you have given is confidential. We cannot give an assurance that confidentiality can be maintained in all circumstances.

☐ Please keep parts of my response confidential

Please tell us if you have any concerns about our publishing any part of your response and explain which parts you would want to keep confidential:

Background questions

First, we would like to ask you for some background information. This will help us to understand the views of specific groups, individuals and organisations and will allow us to better respond to those views.

Are you responding:

☐ as an individual – please go to section A
☐ on behalf of an organisation – please go to section B

Section A: Responding as an individual

Please tell us your:

Name:
Address:
Email:

Where do you live:

☐ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other (please give details):

Are you responding as:

☐ a member of the public
☐ a pharmacy professional or owner – please go to section A1
☐ a pre-registration trainee
☐ a student
☐ other (please give details)
Section A1 – Pharmacy professionals

Are you:

☐ a pharmacist
☐ a pharmacy technician
☐ pharmacy owner

Please choose the option below which best describes the area you mainly work in:

☐ community pharmacy
☐ hospital pharmacy
☐ primary care organisation
☐ pharmacy education and training
☐ pharmaceutical industry
☐ other (please give details)

Section B – Responding on behalf of an organisation

Please tell us your:

name:
job title:
organisation:
address:
email:
a contact name for enquiries:

Please choose the option below which best describes your organisation:

☐ organisation representing patients or the public
☐ organisation representing pharmacy professionals or the pharmacy sector
☐ independent pharmacy (1-5 pharmacies)
☐ Multiple pharmacy (6 or more pharmacies)
☐ NHS organisation or group
☐ research, education or training organisation
☐ other (please give details)

Please provide a brief description of what your organisation does and its interest in this particular consultation:
Consultation questions

We are particularly interested in your views on the following points, although we welcome your comments on any issues that you want to raise about our proposals for revalidation for pharmacy professionals.

The Revalidation framework: process

The revalidation framework sets out our proposals for undertaking, recording and submitting continuing professional development entries.

It covers the following areas:

- Your records: recorded CPD, a peer discussion and a written reflective account
- Submitting records to us and what happens when they are not or cannot be submitted
- Selecting records for review
- Reviewing records and feedback
- Follow up if the review criteria are not met.

Q1 Do you have any comments on any of the steps in the process covered in the framework?

The framework aims to provide further assurance to the public that pharmacy professionals keep their knowledge and skills up to date and remain fit to practise throughout their careers. The changes we are proposing are:

- a simplified approach to CPD recording,
- introducing a peer discussion and
- a reflective account based on the standards for pharmacy professionals

Q2 Do you think the changes above will help to support registrants in their practice and provide assurance pharmacy professionals remain fit to practise?

Yes/ No

Q3 Do you have any comments about the changes we have proposed?

Q4 Do you think the revalidation framework overall will achieve its aim of providing further assurance to users of pharmacy services?

Yes/ No

Q5 Is there anything else, not covered in the framework that you would find useful. Please give details.
Revalidation framework: Impact

**Q6 Do you think that the proposals will have an impact on people using pharmacy services?**

Will that impact be:
- Mostly positive / Partly positive / Both positive and negative / Partly negative / Mostly negative / No impact

**Q7 Do you think that the proposals will have an impact on pharmacy professionals?**

Will that impact be:
- Mostly positive / Partly positive / Both positive and negative / Partly negative / Mostly negative / No impact

**Q8 Do you think that the proposals will have an impact on pharmacy employers?**

Will that impact be:
- Mostly positive / Partly positive / Positive and negative / Partly negative / Mostly negative / No Impact

**Q10 Please provide further comments on the possible impact of the proposals on any of these groups**

**Equality analysis**

We believe revalidation for pharmacy professionals should have positive implications for people. We have not identified any implications that would discriminate against or unintentionally disadvantage any individuals or groups who share particular protected characteristics as set out in the Equality Act 2010.

**Q11 Do you think the proposal might have an impact on certain individuals or groups who share any protected characteristics? Please explain and give examples.**
**Equality Monitoring**

At the GPhC, we are committed to promoting equality, valuing diversity and being inclusive in all our work as a health professions regulator, and to making sure we meet our equality duties.

We want to make sure everyone has an opportunity to respond to our consultation on religion, personal values and beliefs. This equality monitoring form will provide us with useful information to check that this happens. We also want to understand how issues raised in this particular consultation affect different groups. We will use these data as part of our analysis of responses. You do not have to answer these questions if you would prefer not to.

**What is your sex?**

Please tick one box

- ☐ Male
- ☐ Female
- ☐ Other

**What is your sexual orientation?**

Please tick one box

- ☐ Heterosexual/straight
- ☐ Gay woman/lesbian
- ☐ Gay man
- ☐ Bisexual
- ☐ Other
- ☐ Prefer not to say

**Do you consider yourself disabled?**

Disability is defined in the Equality Act 2010 as “physical or mental impairment, which has a substantial and long term adverse effect on a person’s ability to carry out normal day to day activities”. Please tick one box.

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

**What is your age group?**

Please tick one box

- ☐ 16 – 24 years
- ☐ 25 – 34 years
- ☐ 35 – 44 years
- ☐ 45 – 54 years
- ☐ 55 – 64 years
- ☐ 65 + years
What is your ethnic group?

Choose the appropriate box to indicate your cultural background. Please tick one box.

**White**
- ☐ British
- ☐ Irish
- ☐ Gypsy or Irish traveller
- ☐ Other white background (please fill in the box at the end of this section)

**Black or Black British**
- ☐ Black Caribbean
- ☐ Black African
- ☐ Other black background (please fill in the box at the end of this section)

**Mixed**
- ☐ White and black Caribbean
- ☐ White and black African
- ☐ White and Asian
- ☐ other mixed background (please fill in the box at the end of this section)

**Asian or Asian British**
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ other Asian (please fill in the box at the end of this section)

**Chinese or Chinese British**
- ☐ Chinese or Chinese British
- ☐ Other ethnic group (please fill in the box at the end of this section)

**Arab**
- ☐ Arab

**Other**
- ☐ Prefer not to say
- ☐ Other ethnic group background (please give more information in the box below)

What is your religion?
Please tick one box

- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ None
- ☐ Other (please give more information in the box below)
- ☐ Prefer not to say
APPENDIX A – Collated consultation questions

To insert when agreed
Meeting paper

Council meeting on Thursday, 06 April 2017

Public business

Chief Executive and Registrar’s report

Purpose
To keep Council abreast of significant developments

Recommendations
The Council is asked to note this paper

1. Providing safe and effective services online
1.1 The GPhC, GMC, CQC and MHRA have issued a joint statement reminding providers and health professionals working for online primary care services that they must provide safe and effective care.
1.2 The statement emphasises the regulators’ joint commitment to ensuring that the same safeguards are in place for patients whether they have a face to face interaction with a health professional or access services online.
1.3 The GPhC continues to work with the other regulators to share intelligence where we have concerns and take action where necessary to protect patients.

2. Deputy Chief Executive appointment
2.1 We have appointed Megan Forbes as Deputy Chief Executive and Director of Operations. Megan, who will join the organisation from the Financial Conduct Authority, will take up her appointment in June.

3. Collaboration between regulators
3.1 The Chairs and Chief Executives of the health professions regulatory bodies met recently to discuss ways in which inter-regulatory collaboration could be strengthened in ways which are not dependent on changes to legislation.
3.2 From discussions on the day, the following criteria emerged for determining collaborative working priorities:

- Public protection
- Efficiency
- Future proofing
3. Chairs and Chief Executives agreed to discuss with their Councils to identify areas they would be prepared to participate in and lead on.

4. Quality in pharmacy – online workshops

4.1 The first of our online workshops discussing quality in pharmacy has now taken place. The aim of the workshop was to start a conversation within the pharmacy sector to build a shared definition of the key elements of quality and discover the range of actions that those in pharmacy are taking to ensure high quality services are delivered.

4.2 The workshop ran for three weeks across January and February. During this time 1097 participants shared 5587 ideas, votes and comments, together identifying seven important elements that contribute to delivering quality in pharmacy:

- Communicating effectively with service users
- Continuously improving services
- Designing or following standard processes
- Leading effectively
- Maintaining, developing and using professional knowledge and skills
- Speaking about concerns
- Working in partnership with others

4.3 We have now launched our second online workshop to discuss and explore what helps, or hinders, people in delivering each of these elements of quality. When this workshop closes we will analyse all the contributions we have received and publish a report summarising what we have heard. We will use the findings to help shape our priorities for further research on quality in pharmacy, including research to build a greater understanding of the experiences of people using pharmacy services.

5. Committee on Standards in Public Life

5.1 The Chief Executive took part in a round-table workshop with members of the Committee on Standards in Public Life and a number of their stakeholders. The workshop was designed to inform the Committee’s review of the standards and guidance they published in 2014 and 2015 detailing the applicability of the ‘Nolan principles’ to those providing, as well as commissioning, public services – including through private companies. The relevance of this work to community pharmacy was highlighted by the GPhC at our October 2016 event on professionalism under pressure. Further information about the Committee’s current review is available here:

6. **New Zealand pharmacies**

6.1 The Chief Executive, with a number of colleagues, recently took part in a teleconference with senior New Zealand Government officials, at their request, to discuss planned changes to the law on ownership of pharmacies in New Zealand.

**Recommendations**

The Council is asked to note this paper

---

*Duncan Rudkin, Chief Executive and Registrar*  
General Pharmaceutical Council  
duncan.rudkin@pharmacyregulation.org  
Tel 020 3713 7811  
28 March 2017
Meeting paper
Council meeting on Thursday, 06 April 2017

Public business
Engagement and communications report

Purpose
To keep Council abreast of engagement and communications with stakeholders via a quarterly report.

Recommendations
The Council is asked to note this paper.

1. Introduction

1.1. This report outlines key communications and engagement activities in the last quarter and highlights upcoming events and activities.

2. Consultation on religion, personal values and beliefs in pharmacy practice

2.1 The consultation on religion, personal values and beliefs ran from December 2016 to March 2017.

2.2 We received over 3000 written responses, the highest number of responses the GPhC has received for a consultation.

2.3 We also engaged with 134 patients and members of the public and 73 pharmacy professionals and trainees through nine events held across Great Britain. These events included focus groups with registrants and with patients and the public in England, Scotland and Wales, and a roundtable discussion with pharmacy representative organisations.

2.4 The Standards team also held a number of individual meetings with key stakeholders, including organisations representing people with protected characteristics, to hear their views on the consultation. A full list of the events and meetings held during the consultation is included in Appendix 1.

2.5 We used a wide variety of communications channels to maximise participation in the consultation across a diverse range of stakeholder groups and used both general and targeted engagement to reach all potential audiences.
2.6 Digital channels were central to the campaign and our email campaigns were particularly successful. Just over seven thousand registrants clicked through to the consultation webpage after receiving emails promoting the consultation or reading an article in Regulate, and there were two noticeable spikes in responses to the consultation immediately after emails promoting the consultation were sent to registrants in January and February.

2.7 Targeted email campaigns were also effectively used to reach groups representing patients and the public and other health professionals, leading to many of these groups promoting the consultation to members and submitting responses.

2.8 Our social media platforms were also used throughout the consultation to generate discussion and interest in the consultation. Our social media posts on Facebook and Twitter generated 60% of the traffic to the consultation survey, with 35.7% of traffic coming from our website.

2.9 We also promoted the consultation through national and trade media. The Chief Executive was interviewed by three key pharmacy magazines when the consultation launched, with C+D also recording a video interview. The Chief Executive was also interviewed by Radio 4’s Sunday programme at the end of the consultation, with further coverage of the consultation appearing in the Daily Express, Daily Mail and a number of religious titles, including the Tablet.

3. **Consultation on initial education and training standards for pharmacy technicians**

3.1 The consultation on initial education and training standards for pharmacy technicians ran from December 2016 to March 2017. We received 357 written responses to the consultation and participated in 13 events about the consultation across Great Britain, engaging with 297 pharmacy professionals and trainees and 61 patients and members of the public.

3.2 Events included focus groups with patients and the public, and discussions with pre-registration trainees, registrants and education and training leads.

3.3 We worked closely with the Association of Pharmacy Technicians UK (APTUK), with training providers and with employers in community pharmacy and in the NHS to promote the consultation to current trainees and registered pharmacy technicians and to encourage them to respond. During the consultation we engaged with pre-registration trainees and registrants working or training in a wide variety of settings, including community pharmacies, hospitals, prisons and in the army.

3.4 The consultation was also extensively promoted through Regulate, targeted emails to registrants and stakeholders, and social media posts.

4. **Consultation on revised threshold criteria**

4.1 The consultation on revised threshold criteria ran from December 2016 to March 2017.
4.2 We received 62 written responses to the consultation and held five events across Great Britain reaching 36 pharmacy professionals and 61 patients and members of the public.

4.3 The consultation was also promoted through Regulate, targeted emails to registrants and stakeholders, and social media posts.

5. **Joint statement on providing online services**

5.1 We worked with the Care Quality Commission, the General Medical Council, and the Medicines and Healthcare Products Regulatory Agency to develop and publish a joint statement on providing online services safely.

5.2 The statement reminded providers and healthcare professionals working for online primary care services that they must provide safe and effective care. It also highlighted how the regulators are continuing to work closely together to share intelligence where we have concerns and take action where necessary to protect patients.

5.3 The joint press release included a statement from our Chief Executive, which highlighted how we are carrying out further inspections of the pharmacies linked to the online primary care services being inspected by the CQC, to assess whether they are meeting our standards and appropriately addressing the issues and risks linked with online prescribing and dispensing.

5.4 The joint press release was issued to the media on 3 March 2017 and received extensive national coverage, including across the BBC network.

6. **Online workshops on quality in pharmacy practice**

6.1 We promoted the online crowdsourcing workshops to registrants through direct emails, articles in the pharmacy trade media and posts on our social media platforms.

6.2 In our first online workshop, 1,097 participants shared 5,587 ideas, votes and comments, together identifying seven important elements that contribute to delivering quality in pharmacy.

7. **Public affairs activity**

7.1 We have continued to actively monitor relevant developments in the UK Parliament, Scottish Parliament and Welsh Assembly and to provide updates to colleagues.

7.2 Key events in this period include the announcement of plans for a second independence referendum in Scotland, elections in Northern Ireland, the first reading of the Public Health (Wales) Bill and the All Party Pharmacy Group’s evidence sessions for its ongoing enquiry into community pharmacy.
8. Visual brand refresh

8.1 We have taken forward a programme of work to refresh and update our visual branding, and to make sure our branding is used consistently across the organisation.

8.2 We have recently introduced a new set of templates in Microsoft Office which can be used by colleagues across the organisation to quickly and easily create high quality documents which include the appropriate branding. This will make sure that our branding is used correctly and consistently and will introduce efficiencies in both costs and time, as we no longer have to rely on external agencies to produce our corporate documents.

9. Recent meetings

9.1 Listed in Appendix 2 is a non-exhaustive selection of significant meetings held since December 2016.

9.2 Council members are reminded to liaise with the office before accepting external invitations to speak on behalf of the GPhC in order to minimise overlap and to ensure that they have the most up-to-date supporting material.

10. Upcoming events and activities

10.1 Please contact Laura Oakley, Stakeholder Engagement Manager, if you would like to attend any of these events.

10.2 Clinical Pharmacy Congress, London, 12-13 May: Duncan Rudkin will lead a session at the congress on Friday 12 May on ‘Meeting new standards for pharmacy professionals’. Osama Ammar will present on the ‘GPhC’s plans to change CPD and how to give your views’ in the Strategy and Policy Forum on Saturday 13 May.

10.3 Pharmacy Law and Ethics Association (PLEA) Annual Seminar and AGM, London, 17 May: Duncan Rudkin will be discussing the consequences of Brexit for pharmacy regulation at this seminar.

10.4 APTUK conference 2017, Wales, 2 July: Duncan Rudkin is giving a presentation to delegates on assuring that standards are met throughout their careers

10.5 CfP consultation: We are in the process of planning engagement events in London, Manchester, Cardiff and Edinburgh in May 2017 as part of the continuing fitness to practise consultation and will send through invitations to Council members to attend these engagement events once dates and venues are confirmed.

11. Equality and diversity implications

2.1 We are working to embed equality, diversity and inclusion in all of our communications and engagement activities. A key commitment is to effectively engage with a diverse range of audiences and to make sure our events and other engagement activities are as accessible and inclusive as possible.
2.2 A key focus during the consultation on religion, personal values and beliefs was encouraging participation from groups representing people with protected characteristics under the Equality Act 2010 and groups representing other people who may have particular needs or face particular challenges when accessing pharmacy services. A range of channels were used to engage with these groups, including targeted approaches via email and telephone and through offering face-to-face meetings.

Recommendations

The Council is asked to note this paper.

Rachael Oliver, Head of Communications
General Pharmaceutical Council
rachael.oliver@pharmacyregulation.org
Tel 020 3713 7961

30 March 2017
Appendix 1

Consultation events and meetings

1. Consultation on religion, personal values and beliefs in pharmacy practice

Events with:

- Focus group with Redbridge Pensioners Forum (09/01/2017)
- Roundtable with pharmacy representative organisations (23/01/2017)
- Roundtable with organisations representing patients and the public (31/01/2017)
- Patient focus group, London (25/01/2017)
- Patient focus group, Cardiff (15/02/2017)
- Patient focus group, Glasgow (22/02/2017)
- Registrant focus group, Cardiff (15/02/2017)
- Registrant focus group, Glasgow (22/02/2017)
- Registrant focus group, London (28/02/2017)

Meetings with:

- Hindu Council (13/01/2017)
- British Pregnancy Advisory Service (16/01/2017)
- Pharmaceutical Adviser for Health and Justice Commissioning NHS England (16/01/2017)
- Community Pharmacy Scotland (16/01/2017)
- NES (17/01/2017)
- Chief Pharmaceutical Officer, Scotland (14/01/2017)
- Faculty of Sexual and Reproductive Health (30/01/2017)
- Kamson’s Pharmacy (31/01/2017)
- Boots Pharmacy (07/02/2017)
- Morrison’s pharmacy (07/02/2017)
- Family Planning Association (10/02/2017)
- LGBT Foundation (10/02/2017)
- Secular Medical Forum and the National Secular Society (13/02/2017)
- Christian Medical Fellowship (13/02/2017)
- Muslim Council of Britain (14/02/2017)
• Christians in Pharmacy (16/02/2017)
• Guild of Healthcare Pharmacists (21/02/2017)
• Christian Institute (27/02/2017)
• Pharmacy Law and Ethics Association (28/02/2017)
• British Humanist Association (01/03/2017)
• Terrence Higgins Trust (01/03/2017)
• PSNC (02/03/2017)
• Board of Deputies of British Jews (02/03/2017)
• Catholic Bishops Conference of England and Wales (03/03/2017)

2. Consultation on standards for initial education and training of pharmacy technicians

Events with:

• Westminster Kingsway College (14/12/2016)
• APTUK professional committee meeting, London (07/01/2017)
• Combined East of England event, Cambridge (12/01/2017)
• West Midlands Regional Dispensary Manager’s Meeting, Walsall (18/01/2017)
• NHS Education for Scotland, Perth (24/01/2017)
• North East & North Cumbria regional meeting with E&T leads, Newcastle upon Tyne (27/01/2017)
• Preston College (02/02/2017)
• London & South East Pharmacy Technician Education Programme Director/Leads meeting (02/01/2017)
• APTUK London Branch meeting (08/02/2017)
• West College Scotland (20/02/2017)
• Patient focus group, London (25/01/2017)
• Patient focus group, Cardiff (15/02/2017)
• Patient focus group, Glasgow (22/02/2017)
3. Consultation on revised threshold criteria

Events with:

- Patient focus group, London (25/01/2017)
- Patient focus group, Cardiff (15/02/2017)
- Patient focus group, Glasgow (22/02/2017)
- Registrant focus group, Cardiff (15/02/2017)
- Registrant focus group, Glasgow (22/02/2017)

Appendix 2

List of meetings

Listed below is a non-exhaustive selection of significant meetings held during the two months since the last Chief Executive and Registrar’s report to Council.

Initials are as follows: Nigel Clarke (NC), Duncan Rudkin (DR), Hugh Simpson (HS), Claire Bryce-Smith (CBS):

Chair (Nigel Clarke):

- Meeting with Director of Professional Development & Support & Chair, RPS Faculty, Royal Pharmaceutical Society (with DR)
- Meeting with Chair & Head of Corporate Affairs, National Pharmacy Association (with DR)
- Meeting with President & Chief Executive, Royal Pharmaceutical Society (with DR)
- Rebalancing Programme Board (with DR, HS)
- Westminster Health Forum event - Next Steps for patient records and digital inclusion in the NHS
- Kings Fund roundtable discussion - How can we use digital technologies in community pharmacy to optimise services, to benefit and to better engage patients?
- Pharmacy and Public Health Forum meeting
- Royal Pharmaceutical Society National Board Chairs Forum meeting (with DR)

Staff:

- Meeting with Chief Executive, Royal Pharmaceutical Society (DR)
- Meeting with Director of Professional Development & Support & Chair RPS Faculty, Royal Pharmaceutical Society (DR with NC)
- Meeting with Chair & Head of Corporate Affairs, National Pharmacy Association (DR with NC)
- Meeting with President & Chief Executive, Royal Pharmaceutical Society (DR with NC)
- Meeting with Chief Pharmaceutical Officer England (DR)
• CQC Regulation of GP Programme Board (CBS)
• National Quality Board Quality Surveillance Groups and Risk Summit Review Meeting (CBS)
• Rebalancing Programme Board (DR, HS with NC)
• University College London Union Pharmaceutical Society Guest Lecture - Pharmaceutical Ethics and Penalties – speaking (DR)
• Chief Executives Steering Group meeting (DR)
• Meeting with Chair & Chief Executive, Community Pharmacy Wales (DR)
• Westminster Health Forum event - Priorities for improving patient safety in the NHS: regulation, transparency and whistleblowing (DR)
• Chief Executives Legislation Group (DR, HS)
• Professional Standards Authority Conference - for Chairs of Fitness to Practise Panels (CBS)
• Meeting with Chief Executive, Pharmaceutical Society of Northern Ireland (DR)
• Meeting with Chief Pharmacist, National Pharmacy Association (CBS)
• Meeting with Pharmacy Voice (HS, CBS)
• Meeting with Chief Executive, Professional Standards Authority (DR)
• Meeting with Chief Pharmaceutical Officer Wales (HS)
• Committee on Standards in Public Life Roundtable - Ethical Standards for Public Service Providers (DR)
• HEE Pharmacy Assurance Board meeting (HS)
• Royal Pharmaceutical Society National Board Chairs Forum meeting (DR with NC)
Meeting paper

Council on Thursday, 06 April 2017

Public business

Policy and Procedure Review

Purpose
To seek Council’s approval for the policies and documents within its remit that have been recently reviewed.

Recommendations
The Council is asked to approve:

i. the prosecution policy and governance policy with no amendments

ii. the amendments to the raising concerns policy and delegate authority to the Chief Executive and Registrar to update the policy following the appointment of new directors

1. Introduction
1.1. Authority in a number of policy areas is reserved to Council within the Scheme of Delegation. This paper presents the review of a number of those policies and documents and asks for Council’s approval.

2. Prosecution Policy
2.1 The prosecution policy can be found at [https://www.pharmacyregulation.org/sites/default/files/gp201489_gphc_criminal_prosecution_policy.pdf](https://www.pharmacyregulation.org/sites/default/files/gp201489_gphc_criminal_prosecution_policy.pdf)

2.2 There are no proposed amendments to the policy and Council is asked to approve the policy with a three year review period.

3. Governance Policy
3.1 The governance policy can be found at [https://www.pharmacyregulation.org/sites/default/files/gg201598_governance_policy.pdf](https://www.pharmacyregulation.org/sites/default/files/gg201598_governance_policy.pdf)

3.2 There are no proposed amendments to the policy and Council is asked to approve the policy with a three year review period.
4. **Raising Concerns**

4.1 The Raising Concerns policy can be found at Appendix 1. The policy has been updated to reflect changes in senior staff and changes to the chairs of the non-statutory committees. Otherwise, the policy content remains the same.

4.2 Council is asked to approve the amendments to the policy to reflect current arrangements. Council is also requested to delegate authority to the Chief Executive and Registrar to update the senior staff listed in 4.3 when the Deputy Chief Executive and Director of Operations commences in post and when the new Director of OD and EDI is also in post.

5. **Equality and diversity implications**

5.1 Equality and diversity implications are considered in the development of individual policies.

6. **Communications**

6.1 The revised policies and documents will be placed on the GPhC’s intranet and, as they are externally facing, on the website.

7. **Resource implications**

7.1 There are no resource implications arising from this paper.

8. **Risk implications**

8.1 Without clearly defined policies and procedures decisions taken by the GPhC may be subject to challenge.

9. **Monitoring and review**

9.1 Each policy has a review date at which point the effectiveness of the policy is reviewed as well as currency with relevant guidance and best practice. Policies are reviewed earlier if there are changes in legislation which need to be reflected.

**Recommendations**

The Council is asked to approve:

i. the prosecution policy and governance policy with no amendments

ii. the amendments to the raising concerns policy and delegate authority to the Chief Executive and Registrar to update the policy following the appointment of new directors
Matthew Hayday, Head of Governance
General Pharmaceutical Council
matthew.hayday@pharmacyregulation.org
Tel 020 3713 7809

30 March 2017
Raising Concerns
Effective from April 2017

1. Introduction and purpose

1.1 All of us at one time or another has a concern about what is happening at work. Usually these are easily resolved. However, when the concern feels serious because it is about a possible fraud, health and safety, or malpractice that might affect others or the organisation itself, it can be difficult to know what to do.

1.2 You may be worried about raising such a concern and may think it best to keep it to yourself, perhaps feeling it’s none of your business or that it’s only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or to the organisation. You may decide to say something but find that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

1.3 The Council and Chief Executive are committed to running the organisation in the best way possible and to do so we need your help. We have introduced this policy to reassure you that it is safe and acceptable to speak up and to enable you to raise any concern you may have about malpractice at an early stage and in the right way. Rather than wait for proof, we would prefer you to raise the matter when it is still a concern.

If in doubt - raise it!

2. Scope of the Policy

2.1 This policy applies to all those who work for us; GPhC Council members, staff, associates and partners whether full-time or part-time, employed through an agency or as a volunteer. If you have a whistleblowing concern, please let us know.

2.2 If something is troubling you which you think we should know about or look into, please use this policy. If, however, you wish to make a complaint about your employment or how you have been treated, please use the grievance procedure which can be found in the staff handbook. This Whistleblowing Policy is primarily for concerns where the public interest is at risk, which includes a risk to the wider public, staff or the organisation itself.
3. **Our Assurances to you**

3.1 **Your Safety**
   i. The Council and Chief Executive are committed to this policy. Provided you are raising a genuine concern, it does not matter if you are mistaken. Of course we do not extend this assurance to someone who maliciously raises a matter they know is untrue.
   
   ii. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a genuine concern and we consider it a disciplinary matter to victimise anyone who has raised a genuine concern.

3.2 **Your Confidence**
   i. With these assurances, we hope you will raise your concern openly. However, we recognise that there may be circumstances when you would prefer to speak to someone confidentially first. If this is the case, please say so at the outset. If you ask us not to disclose your identity, we will not do so without your consent unless required by law. You should understand that there may be times when we are unable to resolve a concern without revealing your identity, for example where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.
   
   ii. Please remember that if you do not tell us who you are (and therefore you are raising a concern anonymously) it will be much more difficult for us to look into the matter. We will not be able to protect your position or to give you feedback. Accordingly you should not assume we can provide the assurances we offer in the same way if you report a concern anonymously.

4. **How to raise a concern internally**

4.1 Please remember that you do not need to have firm evidence of malpractice before raising a concern. However we do ask that you explain as fully as you can the information or circumstances that gave rise to your concern.

4.2 **Step one:** If you have a concern about malpractice, we hope you will feel able to raise it first with the person who carries out your performance review. This may be done verbally or in writing.

4.3 **Step two:** If you feel unable to raise the matter with your manager, for whatever reason, please raise the matter with:
4.4 These people have been given special responsibility and training in dealing with whistleblowing concerns.

4.5 If you want to raise the matter confidentially, please say so at the outset so that appropriate arrangements can be made.

4.6 **Step three:** If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact (this may be the point at which Council members raise a concern given their position within the organisation):

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive &amp; Registrar</td>
<td>Duncan Rudkin</td>
<td><a href="mailto:Duncan.rudkin@pharmacyregulation.org">Duncan.rudkin@pharmacyregulation.org</a></td>
</tr>
<tr>
<td>Chair of the Council</td>
<td>Nigel Clarke</td>
<td><a href="mailto:Nigel.clarke@pharmacyregulation.org">Nigel.clarke@pharmacyregulation.org</a></td>
</tr>
<tr>
<td>Chair of the Audit &amp; Risk Committee</td>
<td>Digby Emson</td>
<td><a href="mailto:digby.emson@btopenworld.com">digby.emson@btopenworld.com</a></td>
</tr>
<tr>
<td>Chair of the Remuneration Committee</td>
<td>Berwyn Owen</td>
<td><a href="mailto:Berwyn.Owen@wales.nhs.uk">Berwyn.Owen@wales.nhs.uk</a></td>
</tr>
</tbody>
</table>

4.7 The chair of audit and risk committee and chair of remuneration committee are both members of Council. They and the other committee members have responsibility for reviewing some areas of the work within the GPhC and reporting back to the Council. As a result the chairs have a broad understanding of the organisation and have the independence to act on concerns they receive in the same way the Chief Executive and Registrar or Chair of Council would.
5. **How we will handle the matter**

5.1 We will acknowledge receipt of your concern within two working days. We will assess it and consider what action may be appropriate. This may involve an informal review, an internal inquiry or a more formal investigation. We will tell you who will be handling the matter, how you can contact them, and what further assistance we may need from you. If you ask, we will write to you summarising your concern and setting out how we propose to handle it and provide a timetable for feedback. If we have misunderstood the concern or there is any information missing please let us know.

5.2 When you raise the concern it will be helpful to know how you think the matter might best be resolved. If you have any personal interest in the matter, we do ask that you tell us at the outset. If we think your concern falls more properly within our grievance, bullying and harassment or other relevant procedure, we will let you know.

5.3 Whenever possible, we will give you feedback on the outcome of any investigation. Please note, however, that we may not be able to tell you about the precise actions we take where this would infringe a duty of confidence we owe to another person.

5.4 While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly and properly. By using this policy you will help us to achieve this.

5.5 If at any stage you experience reprisal, harassment or victimisation for raising a genuine concern please contact:

| Head of Human Resources | Stuart Walsh | Stuart.Walsh@pharmacyregulation.org |

6. **Independent Advice**

6.1 If you are unsure whether to use this policy or you want confidential advice at any stage, you may contact the independent charity Public Concern at Work on 020 3117 2520 or by email at [helpline@pcaw.org.uk](mailto:helpline@pcaw.org.uk). Their expert staff can talk you through your options and help you raise a concern about malpractice at work.
7. **External Contacts**

7.1 Staff, Council members and associates are encouraged to raise, and attempt to resolve concerns internally. It is nevertheless recognised that there could be circumstances in which it was appropriate to raise a concern externally. In fact, we would rather you raised a matter with the appropriate regulator – such as the Professional Standards Authority, Health and Safety Executive, the National Audit Office or your MP- than not at all. The Professional Standards Authority is responsible for overseeing the UK’s nine health and care professional regulatory bodies including the GPhC. They do not have any legal powers which would allow them to investigate complaints but they do have a policy on how they would respond to a whistleblowing concern raised with them. This can be found on their website [http://www.professionalstandards.org.uk](http://www.professionalstandards.org.uk).

7.2 Public Concern at Work will be able to advise you on using an external contact if you wish.

8. **Monitoring/Oversight**

8.1 The Council is responsible for this policy and will review it annually. Audit and Risk Committee will review the effectiveness of the policy. From time to time Public Concern at Work will be asked to ensure that the policy remains in line with best practice. The Governance Team will monitor the daily operation of the policy and if you have any comments or questions, please do not hesitate to let one of their team know.

<table>
<thead>
<tr>
<th>Policy author:</th>
<th>Matthew Hayday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job title:</td>
<td>Head of Governance</td>
</tr>
<tr>
<td>Policy reference:</td>
<td>GG/2017/144</td>
</tr>
<tr>
<td>Effective from:</td>
<td>06 April 2016</td>
</tr>
<tr>
<td>Review date:</td>
<td>31 March 2018</td>
</tr>
<tr>
<td>Agreed by:</td>
<td>Council [insert date]</td>
</tr>
</tbody>
</table>