General Pharmaceutical Council

Consultation on guidance to ensure a safe and effective pharmacy team

Analysis report

1. Policy background

1.1. Between July and October 2017, we consulted on new guidance for pharmacy owners which outlined what they are expected to do to ensure everyone in the pharmacy team can provide safe and effective services to patients and the public.

1.2. We explained that the current policy framework is out of date and does not reflect the increasingly diverse roles within pharmacy.

1.3. The guidance that we consulted on is intended to support our Standards for registered pharmacies[1], and, in particular, principle 2 of the Standards, which states that "Staff are empowered and competent to safeguard the health, safety and wellbeing of patients and the public". The guidance reflects our ambition to strengthen the regulatory framework around unregistered pharmacy staff. The scope of the guidance extends to all pharmacy staff, including non-registrant managers.

1.4. Whilst the guidance is written for those people who own registered pharmacies, we hope that it will drive consistency across all settings where unregistered pharmacy staff are involved in the delivery of pharmacy services.

1.5. We are considering the issues that have been raised in the consultation and that are detailed in this report. We will publish our finalised guidance in due course.

2. Summary of our proposals

2.1. Having reviewed our current framework of non-statutory accreditation of training programmes for unregistered pharmacy staff, we proposed that we would no longer approve individual training programmes and qualifications for unregistered pharmacy staff.

2.2. We also proposed that the pharmacy owner should be accountable to the GPhC for the training of unregistered staff in their pharmacy, instead of the individual pharmacist, as is currently the case. However, we also recognised that this would not remove the important responsibility of individual pharmacists to delegate tasks only to people who are competent, or to those in training and under supervision.

[1] GPhC (2012) Standards for registered pharmacies, available at https://www.pharmacyregulation.org/sites/default/files/standards_for_registered_pharmacies_september_2012.pdf

2.3. We proposed a new minimum level of competence for pharmacy staff who are involved in dispensing and supplying medicines. In the guidance we proposed that staff must have the knowledge and skills of the relevant units of a nationally-recognised Level 2 qualification, or be training towards this.

2.4. We also proposed that unregistered staff who need further education and training to meet the required competency level for their role should be enrolled on an appropriate training programme within three months of commencing in their role.

3. About the consultation

3.1 Overview

3.1.1. The consultation was open for twelve weeks, beginning on 20 July and ending on 11 October 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. We also received a number of email responses.
- We carried out a short survey for unregistered staff, who were targeted specifically at pharmacy conferences, and sent an email to employers to pass on to their unregistered staff.
- We organised a series of stakeholder events aimed at pharmacy service users, training providers, awarding bodies and key stakeholder organisations representing pharmacy professionals or the pharmacy sector.
- We promoted the consultation through a press release to the pharmacy trade media, via our social media and through our online publication Regulate.

3.2 Surveys

3.2.1. We received **831** responses to our main consultation survey. The vast majority of respondents had completed the online version of the questionnaire, with the remaining respondents submitting their response by email, using the structure of the consultation document.

3.2.2. **708** of these respondents identified themselves as individuals and **123** responded on behalf of an organisation.

3.2.3. Alongside these responses, we received a small number of email responses from organisations writing more generally about their views.

3.2.4. We received **78** responses to our short survey, which targeted unregistered staff and represented a shortened version of the main consultation survey.

3.3 Stakeholder events

3.3.1. The questions in the online survey were also used as a structure for discussion in our stakeholder events, allowing us to capture people's views, and include them in our consultation analysis.

- We organised three patient focus groups – in London, Glasgow and Cardiff
- We held three roundtables – with training providers, pharmacy stakeholders and awarding bodies

- We spoke at the Royal Pharmaceutical Society (RPS) conference and at the Pharmacy Show. We also attended two LPC meetings and a National Pharmacy Association (NPA) Practice and Policy committee meeting to speak about the pharmacy team consultation and other current work.

4. Our approach to analysis and reporting

4.1. Overview

4.1.1. We have considered every response received, as well as notes from stakeholder events. 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.

4.1.2. The different routes through which individuals and organisations could contribute to the consultation meant that some duplication was inevitable. For example, some organisations have met with us at our stakeholder engagement events, and have also submitted a written response. Some organisations were also able to mobilise individual members to respond to us directly. In a few cases, we also received multiple responses from different branches /divisions of the same organisation. To ensure we deal with this fairly, we have treated each response or contribution in its own right, and focused on the issues that have been raised.

4.1.3. The key element of this consultation was a self-selection survey, which was hosted on the Smart Survey online platform. 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.

4.1.4. For transparency, Appendix 1 provides a list of the organisations that have engaged in the consultation through the online survey, email responses and/or their participation in our stakeholder events.

4.2. Our approach to qualitative analysis

4.2.1. This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations (to both the main consultation survey and the short survey), email responses and notes from stakeholder engagement events.

4.2.2. A coding framework was developed to identify different issues and topics in the 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.

4.2.3. The purpose of the analysis was to identify common themes in the responses of those contributing to the consultation, rather than to analyse the differences between specific groups or sub-groups of respondents.

4.2.4. The term ‘respondents’ used throughout the analysis refers to those who responded to the online surveys and those who attended our stakeholder events. It includes both individuals and organisations.

4.3. Our approach to quantitative analysis

4.3.1. The online surveys contained a number of quantitative questions, including yes/no questions and impact rating scales. All responses have been collated and analysed including those submitted by email using the consultation document. Those responding by email more generally about their views are captured under the qualitative analysis only.

4.3.2. Responses have been stratified by type of respondent, so as not to give equal weight to individual respondents and organisational ones (potentially representing hundreds of individuals). These have, however, been presented alongside each other in the tables throughout this report, in order to help identify whether there were any substantial differences between these categories of respondents.

4.3.3. One respondent who had stated that they were responding on behalf of an organisation was reclassified as an individual respondent, based on the responses they had given.

4.3.4. One response was excluded from the analysis as it did not address any of the consultation questions.

4.4. The consultation survey structure

4.4.1. The main consultation survey was structured in such a way that an open-ended question followed each closed question around the proposed approach and draft guidance. This allowed people to explain their reasoning, provide examples and add further comments.

4.4.2. The short survey contained one open-ended question at the end of the questionnaire.

4.4.3. For ease of reference, we have structured the analysis section of this report in such a way that it reflects the order of the consultation questions. This has allowed us to present our quantitative and qualitative analysis of the consultation questions alongside each other, whereby the thematic analysis substantiates and gives meaning to the numeric results contained in the tables[2].

[2] Please note, the tables presenting the breakdown of responses to the short survey are presented in Appendix 2 of this report.

Analysis of consultation responses and engagement activities: what we heard

5. What we heard: Views on proposals regarding the accountability of the pharmacy owner for the training of unregistered staff

Table 1. Pharmacy owner accountability: Breakdown of responses

Do you agree with the proposed approach?	N and % individuals	N and % organisations	Total
Yes	605 **(86%)**	76 **(63%)**	**681**
No	102 **(14%)**	45 **(37%)**	**147**
Total N of responses	**707 (100%)**	**121 (100%)**	**828**

5.1. As reflected in responses to the closed question (see Table 1 above), the majority of respondents felt that this was the right approach. There were, however, differences in the level of support among individual and organisational respondents.

5.2. Rationale for supporting the proposals

5.2.1. Individual respondents were more likely to favour the transfer of accountability for unregistered staff training from the responsible pharmacist onto the pharmacy owner. Organisational respondents who supported the change in accountability, however, had similar reasons to favour the proposals.

5.2.2. The arguments in support of our proposals included the fact that the pharmacy owner is the one in control of financial resources. As such, he or she is responsible for the hiring of staff, for ensuring the appropriate skill mix in the pharmacy, as well as for apportioning budgets, including for staff training. According to respondents, it seemed logical for the pharmacy owner to be held accountable for the training of their staff. Even though respondents agreed with responsible pharmacists' duty to only delegate tasks to those who are competent, they felt pharmacists should not be held responsible for arranging and delivering staff training.

5.2.3. Another argument pointed at the existing pressures on individual pharmacists, with staff training being an additional burden on already overstretched pharmacy professionals. Removing this responsibility was seen as a positive development, as it would free some of their time and allow them to focus on their clinical and patient-centred duties.

5.2.4. Staffing levels, budgets and time available for staff to complete their training were commonly cited problems – with pharmacists having little or no influence over these, unlike pharmacy owners. The profit-making aspect of large multiples was mentioned by some as having an adverse impact on staffing levels and sometimes on investment in staff training.

5.2.5. Some respondents mentioned the case of locum or relief pharmacists acting in the capacity of responsible pharmacists. These pharmacy professionals usually found themselves in an unfavourable

position, meaning that they had little oversight of the training of staff and limited abilities to take action in case of any deficiencies, but, on the other hand, were held accountable for staff operating under their watch. Some argued that, with a greater turnover of pharmacists, it would make more sense and would provide greater consistency if the owner was responsible for this aspect of the running of the pharmacy.

5.2.6. There was recognition of the severe impact that untrained staff can have on the quality of care delivered to patients and the public. It was felt that proposals of holding the owner accountable for this aspect of the business would improve quality across the sector and ensure a certain standard of practice across the board, with pharmacy professionals having confidence in the competence of their staff.

5.3. Rationale for disagreeing with the proposals

5.3.1. Those who disagreed with the proposed approach felt that individual pharmacists had a better understanding of the training needs of staff and were better able to judge their competence due to their day-to-day contact with unregistered staff in the pharmacy. This view was more commonly held among organisational respondents compared to those who responded as individuals. The reasons given for this, however, were the same for both respondent groups.

5.3.2. It was felt by some that if responsibility lay with the owner, this would lead to a tick-box approach, based on hitting specific targets and completing specific modules, rather than on patient safety and local population need.

5.3.3. Some respondents felt that the owner, who might not be pharmacist, might lack the understanding of the training needs of staff in the pharmacy. This responsibility was thus better placed with the superintendent, who is also a GPhC registrant.

5.4. Suggestions for a shared responsibility

5.4.1. It was quite common for respondents to suggest some sort of shared responsibility between the owner and the responsible pharmacist or the superintendent. This was perceived to strike the right balance between the overall training needs of the organisation and the professional's judgement of the skills and competence of their staff. It was felt that the pharmacy owner should be responsible for putting the appropriate mechanisms in place to ensure unregistered pharmacy staff are trained and competent in their roles and for providing the right resources. However, it is the pharmacist who works with unregistered staff every day and is thus best placed to identify any gaps in the training and development needs of their staff. He/she should then advise the owner of the best course of action for specific members of staff. The owner, in turn, is responsible for assessing the perceived gap and addressing it.

5.5. Other issues

5.5.1. Other relevant points raised by organisations included:

- Further guidance on managing potential professional conflict, in cases where the pharmacist takes a different view from the pharmacy owner with regard to the competence of their staff.
- Further clarification on how the GPhC would hold to account those pharmacy owners who are not GPhC registrants, were the proposals to come into effect.

6. What we heard: Views on the areas covered by the proposed guidance

Table 2. Areas covered in the guidance: Breakdown of responses

Does the proposed guidance adequately cover the key areas to ensure a safe and effective team?	N and % individuals	N and % organisations	Total
Yes	601 **(85%)**	94 **(78%)**	**695**
No	104 **(15%)**	26 **(22%)**	**130**
Total N of responses	**705 (100%)**	**120 (100%)**	**825**

6.1. As reflected in responses to our closed question (see Table 2 above), a large majority of respondents were supportive of the guidance and the areas that it currently covers. However, there were a number of suggestions on how it could be improved. Once again, there were certain opinions shared more widely among individuals than among organisations, and vice versa.

6.2. Recognising and acting on specific pressures in pharmacy

6.2.1. Opinions in this regard were more strongly held by individual respondents. They felt that workplace pressures, such as long working hours, the increasing workload of individual pharmacists, funding cuts and insufficient time for training, would hinder the implementation of the guidance.

6.2.2. What many wanted to see expressed in the guidance was the establishment of minimum staffing levels based on the volume of prescriptions or the turnover of the pharmacy. This was to ensure patient safety and to alleviate the pressure and stress levels currently experienced by pharmacy staff.

6.3. Further clarity around training – i.e. how it is delivered, communicated and maintained

6.3.1. A number of respondents asked for further emphasis on the provision of and support for the training of unregistered staff. They felt that it might be difficult for pharmacy owners to provide adequate resources for staff training, including protected learning time. Several respondents thought it would be difficult to ensure that protected time was available for the continued learning and development of unregistered pharmacy staff (especially as this is not currently common practice for registered pharmacy professionals).

6.3.2. Respondents asked for more detail about how pharmacy employers would communicate to pharmacy professionals (including locum staff) that unregistered pharmacy staff have received the required training. This included the availability and accessibility of complete and accurate training records of staff to professionals working in the pharmacy day-to-day, rather than just the owner. Further clarity was also sought in relation to the monitoring of training records, e.g. at the time of inspection, especially for large multiples where these records are often held centrally.

6.3.3. Some respondents mentioned that the requirement for continuing professional development (CPD) and performance management/ appraisal needed to be strengthened in the guidance. Completing the course once and not keeping this knowledge up to date was insufficient (especially given the extensive

CPD requirements for pharmacy professionals) and potentially dangerous from a patient safety point of view.

6.3.4. Some respondents felt that completing the training course off-site or online was not sufficient, as the work of unregistered pharmacy staff often involves face-to-face interactions with patients. Work-based practice was therefore a vital element of any such training and had to be explicitly recognised in the guidance.

6.3.5. There was a point, which was also made in response to other consultation questions, around the definition of responsibility and accountability for unregistered staff training. Many shared the view that the responsible pharmacist must have the final say on the level of training which is adequate for a given member of staff. There should also be provisions for the pharmacist to challenge the view of the owner, in cases where he/she disagrees with their decision.

6.3.6. There were also a few mentions of the case of pharmacy students and the awkward situation that they would find themselves in, if they had to undertake an NVQ on top of their studies. It was felt that there should be a specific exemption for them noted in the guidance.

6.4. Details on policing the guidance

6.4.1. Some respondents argued that more clarity was needed around the monitoring and enforcement of the guidance. They felt that there should be provisions for support and scrutiny of pharmacy owners in relation to the guidance, as well as for disciplinary procedures and sanctions in case of non-compliance. This was raised specifically in relation to non-pharmacist managers, who are not GPhC registrants.

6.5. Guidance is too prescriptive / onerous

6.5.1. Some organisational respondents felt that the guidance was too prescriptive and could be too onerous, especially for part-time staff. The lack of flexibility regarding the level of training required was particularly unwelcome by some and was seen at odds with other GPhC publications – e.g. the standards for registered pharmacies.

6.6. Other suggested additions

6.6.1. The following were mentioned by some respondents as areas requiring further emphasis in the guidance:

- Communication and clinical / consultation skills
- An established whistleblowing process (which would provide for the raising of concerns about the number, skills and training of staff)
- Confidentiality
- Safeguarding
- Data protection
- Awareness of equality, diversity and cultural sensitivities
- An explicit focus on patient safety
- The behaviours and character of unregistered staff

7. What we heard: Views on proposals for the education and training requirements – Level 2 qualification

Table 3. Education and training requirements: Breakdown of responses

Do you agree with the minimum level of competence for unregistered pharmacy staff who are involved in dispensing and supplying medicines?	**N and % individuals**	**N and % organisations**	**Total**
Yes	529 **(75%)**	59 **(49%)**	**588**
No	176 **(25%)**	62 **(51%)**	**238**
Total N of responses	**705 (100%)**	**121 (100%)**	**826**

7.1. As reflected in responses to the closed question on minimum level of competence for unregistered staff (see Table 3 above), organisational respondents were much more likely to have concerns about this proposal, compared to individual respondents.

7.2. Rationale for agreement with NVQ/SVQ Level 2 qualification proposals

7.2.1. A large number of respondents who provided further comments on this matter agreed that the proposed approach ensured an adequate level of qualification. A major benefit of the proposal was that it provided a level of consistency and standardisation across the field which was a positive step forward. A move to an NVQ/SVQ system was perceived as a way to enable pharmacy to maintain public trust and confidence over the longer term, in a landscape of increased patient expectations of getting access to expert and well-informed advice and high quality services.

7.3. Rationale for disagreement with NVQ/SVQ Level 2 qualification proposals

7.3.1. Many respondents found the move to a specific qualification unwelcome and too prescriptive. They appreciated the current flexibility to select from a variety of equivalent choices for the same required standard. These respondents thought that the current system was of a high quality and did not need to be replaced – a move from the current system was seen as unnecessary and counterproductive. The removal of the words "or equivalent" was seen as particularly problematic.

7.3.2. A number of respondents explained that the assurance for employers that their staff have the required knowledge and skills currently derives from the completion of GPhC-approved courses. These were seen to:

- provide a good minimum level of competence
- already be used and understood by employers
- work well for the benefit of patient safety and the image of pharmacy

7.3.3. Concern was voiced in relation to GPhC's withdrawal from the accreditation of courses. There was fear that, in time, some providers of NVQ/SVQ courses might diverge from the recognised standards and, without the oversight of the GPhC, the owner or superintendent would not be able to react to this change. It was felt that the quality assurance function should be retained, and were the GPhC to withdraw from its provision, then another reputable organisation should step in and provide this level of assurance. Professional bodies such as the Royal Pharmaceutical Society (RPS) and the Association of Pharmacy Technicians, UK (APTUK) were considered best placed to undertake such a role. There was also a mention of the possibility for a peer review system to support innovation and best practice.

7.3.4. Respondents who opposed the proposal also pointed at the burden of a formal NVQ/SVQ Level 2 qualification compared to existing courses. A nationally recognised vocational qualification was considered more expensive and more onerous for both the trainee and their supervisor. Some also noted that a course like this would be prohibitive for certain demographics – e.g. older people – who would struggle with the rigid nature of the course, as well as the length of time needed to complete it. Respondents suggested this would impact on the attractiveness of these pharmacy roles and the ability of pharmacy to recruit among such demographics. Respondents felt that equivalent accredited courses should remain an alternative way to achieve the minimum level of competence.

7.3.5. Another difficulty was foreseen with regard to those who have already completed a relevant course and were practising effectively. Respondents sought clarity on whether these staff would need to retrain or whether grandparenting could apply.

7.3.6. Below are some of the other concerns that we picked up from the consultation responses:

- Some respondents explained that a formal level of qualification did not necessarily translate into high quality staff.
- Some thought the proposed level of qualification was too low and should be the absolute minimum required of people in patient-facing roles. CPD was deemed crucial in this regard.
- Some thought the level of qualification should not be set in stone, but should depend on unregistered staff's role in the pharmacy, and be up to the owner to determine.
- Some respondents called for additional guidance from the GPhC regarding the relevant units of a Level 2 qualification required, rather than leaving this to the owner's discretion.
- Some participants in our roundtable events discussed the differences between NVQs and SVQs and the fact that NVQs are not future-proof. Some felt that NVQs/SVQs did not cover the increasing range of roles and responsibilities of unregistered staff.
- Several respondents questioned the feasibility of the proposals in the case of pharmacy students and pre-registration trainees. They thought that completing a formal NVQ/SVQ was disproportionate in their case.

8. What we heard: Views on proposals for training to start within three months of employment

Table 4. Start of training within three months of employment: Breakdown of responses

Do you agree with our proposed approach?	N and % individuals	N and % organisations	Total
Yes	526 **(75%)**	64 **(53%)**	**590**
No	180 **(25%)**	57 **(47%)**	**237**
Total N of responses	**706 (100%)**	**121 (100%)**	**827**

8.1. There were differences among individuals and organisations in relation to our proposal. Support for the three month period for commencing training was much wider among individual respondents compared to organisational ones (see Table 4 above). However, the reasons for supporting or opposing the proposals were similar across the two groups of respondents.

8.2. Rationale for agreement with the proposed timescale

8.2.1. The majority of respondents thought that three months was an appropriate timeframe for the commencement of training for unregistered staff. This was considered good from a patient safety point of view, as well as for the unregistered staff themselves. It was frequently mentioned that this would help unregistered staff in their job and stop them from forming 'bad habits'.

8.2.2. It was felt that three months was a suitable period with regard to probationary periods, induction and familiarisation with the workplace.

8.2.3. A set standard for the commencement of training was also perceived as a way to provide consistency and quality across the sector.

8.2.4. Some suggested that unregistered staff should be enrolled on a course within the three months, but not necessarily commenced the course in that period.

8.3. Rationale for disagreement with the proposed timescale

8.3.1. Those who disagreed often indicated that three months is usually the length of probationary periods, so it would be inappropriate to commence the training during this time. Some felt that unregistered staff should be enrolled on a course straight after the probationary period has ended and their suitability for the role has been established. Four and six months were indicated as alternative options.

8.3.2. Some respondents expressed concern that this time limit is not always feasible for commencement of training and that very restrictive or legislative constraints add to the existing workload and financial pressures in pharmacy. For example, this proposal might mean investing in a course for someone who does not pass their probationary period or decides to leave soon after that. Another argument concerned staff with irregular working patterns, such as part-time working, which made a defined timeframe for commencement of training impractical, unfeasible or unjustified in some cases.

8.3.3. Other respondents held an opposing view – namely that unregistered staff should be enrolled on an appropriate course as soon as they start in their role. This was to ensure that they know what is expected of them as early as possible and are competent for their roles, which are often responsible and patient-facing. One month was indicated as an alternative timeframe for commencing the course, in the interest of patient safety.

8.3.4. There was also a shared view among some that an arbitrary period of three months for commencement of training might be inappropriate or too short, but a defined timeframe for completing such training was desirable.

8.3.5. Organisational respondents were more likely to favour the option of extending the suggested three-month period, in view of probationary periods and to avoid the cost of investing in someone who might not be suitable for the role or was likely to leave the workplace. Individual respondents, on the other hand, tended to mention a shorter timeframe for commencing the training for unregistered staff more often. This was to make sure that people are competent and safe to operate as soon as they join the pharmacy.

9. What we heard: Views on the impact of the proposed changes

Table 5. Impact on pharmacy owners: Breakdown of responses

What kind of impact do you think the proposals will have on pharmacy owners?	**N and % individuals**	**N and % organisations**	**Grand total**
No impact	23 **(3%)**	0 **(0%)**	**23**
Mostly positive	232 **(33%)**	26 **(21%)**	**258**
Partly positive	39 **(6%)**	6 **(5%)**	**45**
Positive and negative	283 **(40%)**	36 **(30%)**	**319**
Partly negative	44 **(6%)**	7 **(6%)**	**51**
Mostly negative	82 **(12%)**	46 **(38%)**	**128**
Total N of responses	**703 (100%)**	**121 (100%)**	**824**

Table 6. Impact on pharmacy professionals: Breakdown of responses

What kind of impact do you think the proposals will have on pharmacy professionals?	**N and % individuals**	**N and % organisations**	**Grand total**
No impact	25 **(4%)**	3 **(2%)**	**28**
Mostly positive	420 **(60%)**	41 **(34%)**	**461**
Partly positive	65 **(9%)**	7 **(6%)**	**72**

Positive and negative	91 **(13%)**	29 **(24%)**	**120**
Partly negative	35 **(5%)**	18 **(15%)**	**53**
Mostly negative	67 **(10%)**	23 **(19%)**	**90**
Total N of responses	**703 (100%)**	**121 (100%)**	**824**

Table 7. Impact on unregistered pharmacy staff: Breakdown of responses

What kind of impact do you think the proposals will have on unregistered pharmacy staff?	**N and % individuals**	**N and % organisations**	**Grand total**
No impact	18 **(3%)**	1 **(1%)**	**19**
Mostly positive	363 **(52%)**	44 **(37%)**	**407**
Partly positive	55 **(8%)**	7 **(6%)**	**62**
Positive and negative	143 **(20%)**	32 **(27%)**	**175**
Partly negative	45 **(6%)**	7 **(6%)**	**52**
Mostly negative	76 **(11%)**	29 **(24%)**	**105**
Total N of responses	**700 (100%)**	**120 (100%)**	**820**

Table 8. Impact on people using pharmacy services: Breakdown of responses

What kind of impact do you think the proposals will have on people using pharmacy services?	**N and % individuals**	**N and % organisations**	**Grand total**
No impact	56 **(8%)**	16 **(13%)**	**72**
Mostly positive	483 **(69%)**	50 **(41%)**	**533**
Partly positive	44 **(6%)**	7 **(6%)**	**51**
Positive and negative	65 **(9%)**	23 **(19%)**	**88**
Partly negative	15 **(2%)**	5 **(4%)**	**20**
Mostly negative	42 **(6%)**	20 **(17%)**	**62**
Total N of responses	**705 (100%)**	**121 (100%)**	**826**

9.1. As reflected in responses to the respective closed questions (see tables 5, 6, 7 and 8 above), respondents held a wide range of views around the potential impact of the proposals.

9.2. Generally positive views

9.2.1. Respondents on the positive end of the spectrum thought that the proposals would have a welcome impact on patient safety. They thought that better trained pharmacy staff was a benefit to everyone, ensuring:

- consistency across the sector
- a reliable workforce for the owner
- adequate support for the pharmacist, and
- unregistered staff who are better equipped to serve patients and the public

9.2.2. However, it was frequently mentioned that the success of the guidance and its proposals would depend on how the GPhC enforces and polices the initiative. It was felt that the obligations under the guidance should be monitored during pharmacy inspections. A potential problem was envisaged with regard to the lack of direct contact with owners of body corporates during inspections. A question was raised around the consequences of non-compliance and the sanctions that might be imposed on pharmacy owners in such case.

9.3. Negative impact on owners and pharmacy management

9.3.1. A frequently mentioned concern was around the added burden of NVQs/SVQs compared to the current GPhC-accredited courses. This was envisaged in terms of the direct training cost, but also in terms of the added managerial time, administration, and in-house training/development time. NVQs were seen to be more time consuming and more onerous for both the trainee and their tutor, compared to current programmes. Some felt that this might discourage new applicants and might make recruitment and retention difficult, at least in the short term.

9.3.2. Some respondents felt that this added financial and bureaucratic burden was particularly problematic at a time of challenged pharmacy budgets, and might have negative consequences on patient care. For example, it might discourage some owners from making staff additions or even providing certain services.

9.3.3. These proposals were seen to have a greater negative impact on independent pharmacy owners compared to owners of multiples due to the added financial burden of training on their overstretched budgets.

9.4. Negative impact on pharmacists

9.4.1. According to some respondents, there might be a potential negative impact on pharmacists, due to the managerial burden of NVQs, as they are the ones who would be delegated to provide the training.

9.5. Negative impact on unregistered pharmacy staff

9.5.1. The disproportionate impact on part-time staff was reiterated.

9.5.2. There was also a mention of the issue of grandparenting and that this needed to be resolved.

9.6. Negative impact on users of pharmacy services

9.6.1. A number of respondents mentioned the potential for inconsistencies in the skills and qualifications of unregistered staff, and failing standards in pharmacy, were the GPhC to remove itself from the responsibility of approving courses. Some respondents felt that the public perception of pharmacy would suffer from the lack of officially recognised courses.

9.6.2. A view was also expressed that the tone of the guidance might suggest to members of the public that there are widespread concerns over the safety and effectiveness of the current system. In fact, there was no clear evidence that this was the case, so there was no need to "fix what was not broken".

10. What we heard: Views on the impact of the proposed changes on individuals or groups who share any of the protected characteristics

Table 9. Impact on individuals or groups sharing any of the protected characteristics: Breakdown of responses

Do you think the proposal might have an impact on certain individuals or groups who share any of the protected characteristics?	**N and % individuals**	**N and % organisations**	**Grand total**
Yes	108 **(15%)**	28 **(24%)**	**136**
No	591 **(85%)**	91 **(76%)**	**682**
Total N of responses	**699 (100%)**	**119 (100%)**	**818**

10.1. As reflected in responses to our closed question on the potential impact of proposals on individuals or groups sharing any of the protected characteristics (see Table 9 above), the majority of respondents did not tend to envisage such an impact.

10.2. Respondents who did envisage such an impact mentioned the following groups as potentially disadvantaged by the proposals:

- Unregistered staff with learning disabilities, dyslexia, or those who require reasonable adjustments. Those who struggle with formal learning, but are not impaired when it comes to practical learning, were also mentioned.
- Part-time workers, who are more likely to be disabled, younger, older or contemplating pregnancy / being back from maternity leave. For these employees it might be more difficult to complete the training or to be assessed appropriately and enrolled on a course within the three-month timeframe from commencing their role.
- Older staff who may have been in the profession for years but would see themselves forced to undertake academic studies and might not be willing to or able to do that.
- Staff for whom English is not their first language

- Undergraduate pharmacists, who would be required to complete an NVQ/SVQ on top of their university studies
- Vulnerable groups with protected characteristic among pharmacy service users, who would suffer from the potential consequences of the move away from GPhC-accredited courses – e.g. inconsistency in the skills and capabilities of unregistered staff.

10.3. Some respondents highlighted the potential impact of the changes on already overworked and overstressed pharmacists. They thought that the added pressure of an even more onerous system could trigger mental instability, depression or anxiety in pharmacy professionals.

10.4. There was also an appreciation of the importance of equality training for unregistered staff. Respondents agreed with the importance of recognising and dealing professionally with cultural sensitivities and the protected characteristics of patients and members of the public.

11. Respondent profile

11.1. A series of introductory questions sought information on individuals' general location, and in what capacity they were responding to the survey. For pharmacy professionals, further questions were asked to identify whether they were pharmacists, pharmacy technicians or pharmacy owners, and in what setting they usually worked. For organisational respondents, there was a question about the type of organisation that they worked for. The tables below present the breakdown of their responses.

11.2. Category of respondents

Table 10. Responding as an individual or on behalf of an organisation

Are you responding:	**N**	**% of total**
As an individual	708	85%
On behalf of an organisation	123	15%
Total N of responses	**831**	**100%**

11.3. Profile of individual respondents

Table 11. Individual respondents - countries

Where do you live?	**N**	**% of total**
England	575	83%
Scotland	79	11%
Wales	28	4%
Northern Ireland	3	0%
Other	11	2%

Total N of responses	**696**	**100%**

Table 12. Profile of individual respondents

Are you responding as:	**N**	**% of total**
A pharmacy professional or pharmacy owner	673	95%
A member of the public	20	3%
A pre-registration trainee	6	1%
A student	1	0%
Other[3]	8	1%
Total N of responses	**708**	**100%**

Table 13. Profile of pharmacy professionals

Are you:[4]	**N**	**% of total**
A pharmacist	522	74%
A pharmacy technician	140	20%
A pharmacy owner	46	6%
Total N of responses	**708**	**100%**

Table 14. Pharmacy professionals: area of work

Please choose the option below which best describes the area you mainly work in:	**N**	**% of total**
Community pharmacy	489	73%
Hospital pharmacy	84	13%
Primary care organisation	42	6%

[3] Please note, some respondents identified themselves as "other"; however, they were added to either the pharmacist or pharmacy technician category based on their description of their role.

[4] Please note, the total number of pharmacy professionals presented in this table is larger than the one reported in the previous table. This is due to the fact that a number of pharmacy owners are also pharmacists or pharmacy technicians, so they would have been included in both categories.

Pharmacy education and training	17	3%
Pharmaceutical industry	8	1%
Other	30	4%
Total N of responses	**670**	**100%**

11.4. Profile of organisational respondents

Table 15. Organisational respondents: type of organisation

Please choose the option below which best describes your organisation:	**N**	**% of total**
Organisation representing patients or the public	3	2%
Organisations representing pharmacy professionals or the pharmacy sector	22	18%
Independent pharmacy (1-5 pharmacies)	62	50%
Multiple pharmacy (6 or more pharmacies)	17	14%
NHS organisation or group	8	7%
Research, education or training organisation	6	5%
Other	5	4%
Total N of responses	**123**	**100%**

11.5. Profile of respondents (short survey)

Table 16. Profile of respondents (short survey)

What is your current role in the pharmacy team?	**N**	**% of total**
Dispensing assistant	41	54%
Registered pharmacist	17	22%
Registered pharmacy technician	6	8%
Pharmacy manager who is not registered with the GPhC	5	7%
Medicines counter assistant	5	7%
Trainee technician	1	1%
Trainee dispenser	1	1%
Total N of responses	**76**	**100%**

Appendix 1: Organisations

The following organisations engaged in the consultation through the online survey, email responses and stakeholder meetings:

A J Gilbert (Chemist) Ltd

A P Chemist Ltd

A.F. Browne Ltd T/A Brownes Chemist

Abalane Ltd

Alcura Ltd

All Wales Principal Pharmacist for Education

Allesley Pharmacy

AMF Medica

Anna healthcare ltd

Ashburton Pharmacy

Association of Pharmacy Technicians UK (APTUK)

Association of the British Pharmaceutical Industry (ABPI)

Avicenna plc

Barons Pharmacy Ltd

BJ Wilson Ltd

Boots' Pharmacist Association

Boots UK

Buttercups Training

Cambridge University Hospitals NHS Foundation Trust

Camden and Islington LPC

Celesio UK

Central and North West London NHS Foundation Trust

Chelmack Ltd

City and Guilds of London Institute

Clarity Pharmacy

Clockwork Pharmacy

Communications International Group CIG

Community Pharmacy Scotland

Community Pharmacy Wales

Company Chemists' Association

Craigavon Area Hospital

Cranston Ltd

Dalston Pharmacy Ltd

Devon Local Pharmaceutical Committee

Dickson Chemist

Direct2Chemist

Dorset LPC

Dumlers pharmacy

East Sussex LPC

Education and Training Operational sub-group of the Welsh Chief Pharmacists Committee

Essentials

Fagley Pharmacy

Fourway Pharmacy

Gallagher Healthcare Ltd

Green Light Pharmacy

Griffiths Pharmacy

Grove Park Pharmacy

Guild of Healthcare Pharmacists

Guild of Healthcare Pharmacists (Scottish division)

H A McParland Group

Halton St Helens and Knowsley LPC

Hampshire Pharmaceuticals Limited

Health Education England

Health Education England (London & South East)

Healthwatch Dudley

Hive

Howells & Jolley

Howells and Harrisons (Southend) Ltd

Ian Morton Ltd

Jade Pharmacy Group

Jhoots Pharmacy

John P Fenton and Sons Ltd

John Ross Chemist/Ltd

Kent LPC

Kings Health Pharmacy

LGBT foundation

Lo's Pharmacy group

Lords Pharmacy Ltd

Masons Chemists

Massinghams chemist

Meanwood Pharmacy

Mediapharm ltd

Medichest Ltd

MediShop Ltd & Boreham EA Ltd

Medix Pharmacy

Mildcare Ltd

Mirash Ltd

MJ Roberts Chemist Ltd

Mornicrest Ltd

Nashi Ltd

National Clinical Homecare Association

National Pharmacy Association

NHS Education for Scotland

NHS GG&C APC

NHS Highland

NHS Scotland Directors of Pharmacy Group

Parkinson's UK

PC Pharmacies Ltd

Pearl Chemist Ltd

Perfucare Pharmacy

Pharm@Sea

Pharmaceutical Services Negotiating Committee

Pharmacists' Defence Association

Pharmacy Forum

Pharmacy Team Ltd

Pharmacy Thames Valley

Pleck Pharmacy

Polypharm Ltd

Rains Pharmacy

Rowlands Pharmacy

Royal Pharmaceutical Society

RTCP

Scientia skills

Scott the Chemist

Scottish Qualifications Authority

Shivas Pharmacy Ltd

South Staffordshire Local Pharmaceutical Committee

SPM Network - Hospital Workforce Development Group

St Helen's Millenium Centre Pharmacy

Sterling Pharmacy

Suffolk LPC

Sutton Associates Ltd

Swindon and Wiltshire LPC

Tanna Pharmacy

Tele Chem Pharmacy

The Nelson Pharmacy

The University of Manchester

The Village Pharmacy

Theydon Bois Pharmacy

V U Chem Ltd

Walsall Local Pharmaceutical Committee

Weldricks Pharmacy

Wemyss Bay Pharmacy

Wolverhampton LPC

Workforce Education Development Service

Wraysbury Village Pharmacy

Appendix 2: Responses to consultation questions (short survey)

Table 17. Pharmacy owner accountability: Breakdown of responses (short survey)

Do you agree that the pharmacy owner, instead of the pharmacist, should be responsible for making sure that unregistered staff have the appropriate training and are competent for their roles?	**N**	**% of total**
Yes	62	79%
No	16	21%
Total N of responses	**78**	**100%**

Table 18. Education and training requirements: Breakdown of responses (short survey)

Do you agree that unregistered staff should have to complete the relevant units of an NVQ/SVQ Level 2 qualification?	**N**	**% of total**
Yes	71	91%
No	7	9%
Total N of responses	**78**	**100%**

Table 19. Start of training within three months of employment: Breakdown of responses (short survey)

Do you agree that unregistered staff should have to start their training within three months of starting the role?	**N**	**% of total**
Yes	69	88%
No	9	12%
Total N of responses	**78**	**100%**

Table 20. Impact of proposals on respondents: Breakdown of responses (short survey)

What impact do you think the proposals will have on you?	**N**	**% of total**
No impact	14	18%
Mostly positive	45	58%
Partly positive	6	8%
Positive and negative	9	12%
Partly negative	2	3%
Mostly negative	2	3%
Total N of responses	**78**	**100%**