General Pharmaceutical Council

Consultation on delivering equality, improving diversity and fostering inclusion: our strategy for change 2021-26: analysis report

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Section 1: Executive summary

Between April and July 2021, we consulted on our draft Equality, Diversity and Inclusion Strategy *"Delivering* equality*, improving diversity and fostering inclusion: our strategy for change 2021 – 2026".* In particular, we sought views on the following:

- The three strategic themes outlined in our proposal
- The objectives and outcomes under each of these themes
- The impact of our proposals

The strategy sets out a framework for how we will embed considerations of equality, diversity and inclusion in all aspects of our work as a regulator and as an employer. We believe this will help us to demonstrate our commitment to this vital area of work, whilst at the same time securing the confidence of all our stakeholders.

The strategy will also help us deliver on our commitments in our 2030 Vision "Safe and effective pharmacy care at the heart of healthier communities" and our Strategic Plan. The strategy also describes how we meet our obligations and supports us to achieve more than compliance with strict legal requirements in this area.

Summary of key findings

Views on our strategic themes

Overall, the three strategic themes received strong support during the consultation. The vast majority of respondents either agreed or strongly agreed that these were appropriate (representing over 80% across each theme). In contrast, across each theme, only a modest percentage of respondents neither agreed, disagreed or didn't know, and a very small percentage disagreed or strongly disagreed with the proposals.

Views on our strategic objectives

Similarly, the strategic objectives received a favourable response. The majority of respondents stated that they either agreed or strongly agreed that these were appropriate (just under 80% across each set of objectives). In contrast, only a modest percentage of respondents neither agreed, disagreed or didn't know, and a very small percentage disagreed or strongly disagreed with the proposals.

Views on our strategic outcomes

This trend continued in relation to the strategic outcomes. Overall, the outcomes for all themes were well received, with the majority of respondents stating that they either agreed or strongly agreed that these were appropriate (again, just under 80% across each set of outcomes). As with the themes and objectives, only a modest percentage of respondents neither agreed, disagreed or didn't know, and a very small percentage disagreed or strongly disagreed with the outcomes.

Views on impact

Through the consultation, we sought wider views on the potential impact of the proposals on any individuals or groups sharing legally protected characteristics under the Equality Act 2010, including whether the impact would be positive, negative or mixed. We also sought views about the impact of our proposals on any other individuals or groups (not related to the protected characteristics), for example patients, pharmacy owners or pharmacy staff. Given the variety of impacts considered, we have not sought to summarise the feedback in this section and instead this is set out in the relevant sections of the report below (please see pages 26 – 30 for more information).

There is a more detailed breakdown and analysis of each element of the consultation, including the breakdown between individual and organisational respondents, in Section 3 below.

Section 2: About the consultation

Overview

The consultation was open for 12 weeks, beginning on 19 April 2021 and ending on 12 July 2021. To make sure we heard from as many individuals and organisations as possible, we did the following:

- created a dedicated page on our website with a press-release, an overview of the proposal and links to the full consultation document and an online survey. The consultation was also promoted through a press release to the pharmacy trade media, via our social media and through our e-bulletin Regulate.
- circulated the online survey to a large variety of stakeholders and made it available for individuals and organisations to complete during the consultation period. We also accepted email responses, a few of which provided feedback without necessarily following the survey structure.
- organised a series of wider stakeholder events and focus groups, which were attended by members or the public and key organisations across the three nations representing patients and patient advocacy groups and health charities; professional and trade bodies representing pharmacists and pharmacy technicians; pharmacy specific protected characteristics groups; and other wider equality groups.
- organised a series of one-to-one meetings with a range of patient and pharmacy groups and networks who were unable to attend other stakeholder events or had a particular interest in the subject matter of the consultation.

Survey

We received an encouraging total of **279** written responses to our consultation. **251** of these respondents identified themselves as individuals and **28** responded on behalf of an organisation.

Of these responses, 272 responded to the online consultation survey (250 individuals and 22 organisations).

Alongside these, we received 7 responses from individuals (1) and organisations (6) writing more generally about their views.

Stakeholder events

Our stakeholder events and focus groups were designed to create opportunities for thoughtful and dynamic discussions, to receive feedback from patient, pharmacy and other health and equality focussed stakeholders and to drive completion of the online survey.

Broadly, the questions in the online survey were also used as a structure for discussion in our stakeholder events, with some adaptation for the events with members of the public to ensure full understanding of our proposals. This approach allowed us to capture stakeholders' views, and to include them in our consultation analysis. The stakeholder events and focus groups included plenary and small

breakout group discussions, to ensure that all attendees were able to contribute and share their views, experiences and opinions.

Because of the Covid-19 pandemic, all engagement events were virtual.

We held **1 stakeholder event** on Zoom which was attended by a mix of pharmacists, pharmacy technicians, delegates from pharmacy professional and trade bodies, and other wider health and equality groups and organisations.

We organised **2 patient focus groups** which also took place on Zoom and were attended by individuals from across England, Scotland and Wales.

In total, just under **60 individuals and representatives** of organisations participated in these events.

Several Council members also attended the stakeholder events and focus groups as observers. Their role was to listen to feedback from delegates, so they can use what they heard through the engagement events, as part of wider Council discussions on next steps.

Other engagement activities

During the consultation period, we also carried out wider engagement activities, including:

- presenting at a number of external events, meetings and seminars run by other organisations, to raise awareness about the strategy, drive completion of the online survey and seek initial feedback and views.
- raising awareness about the strategy through other regular meetings with stakeholders, including across Scotland and Wales (this was over and above the specific one-to-one meetings described above).
- inviting the Equalities and Human Rights Commission to review our strategy and to share key insights about current external issues and challenges in the wider context from their perspective. At the April 2021 Council meeting, the Executive Director of the Equality and Human Rights Commission welcomed the strategy and provided overall feedback and suggestions for implementation within the wider context of health and social inequalities.

Social media

We monitored social media activity during the consultation period. There was no specific feedback to collate and include in this analysis from social media activity that we identified. Overall, throughout the 12-week window, we had good external engagement in terms of 'likes' and retweets.

NB. See **Appendix 1: Our approach to analysis and reporting** for full details of the methods used, **Appendix 2: Respondent profile** for a breakdown of who we heard from, and **Appendix 3: Organisations** for a list of organisations who responded. **Appendix 4: Consultation questions** contains a full list of the questions asked in the consultation survey.

Section 3: Analysis of consultation responses and engagement activities

Overview

In this section, we provide an overview of the general feedback and comments about the overall strategy and approach, before moving on to the feedback on each specific aspect of the consultation.

Broadly, individuals and organisations who responded to our consultation survey, as well as stakeholders who attended the engagement events, focus groups or one-to-one meetings, were supportive of the principles outlined across all three themes and felt the proposals represented a positive step and the right direction of travel for the GPhC.

It is also important to highlight from the outset that a large majority of respondents supported the three themes and their objectives and outcomes and selected the 'agree/strongly agree' options in their survey responses, either without providing further explanatory comments or making detailed observations. This trend is clearly noticeable in the figures supporting the quantitative analysis.

On the other hand, the minority of respondents who indicated their disagreement with the proposed three themes and their objectives and outcomes, tended to qualify their views on multiple occasions. Across the consultation, a small number of individual respondents also pointed out their personal disaccord with EDI in societal terms, including their views on the prevalence of discrimination or prejudice in contemporary Great Britain, and the role of EDI in pharmacy regulation.

Many respondents welcomed the strengthened commitment to embedding EDI across everything we do as a regulator and employer and supported the holistic approach of looking beyond the legally protected characteristics through our work, where possible. Some respondents gave examples of the broader issues that could be considered through our work and these are discussed in more detail below.

In particular, the majority of organisations we engaged with welcomed the opportunity to respond to the consultation and were supportive of the strengthened approach to EDI, and the overall direction of travel set out in the draft strategy. Some organisations provided thoughts, ideas and suggestions for other pieces of work or initiatives that could be taken forward across all three themes. These will be reviewed in more detail, as we develop our EDI strategy action plan in the next phase of this work.

A number of respondents acknowledged that this is a complex and fast-moving area of work, and that some issues and challenges are outside the scope of the GPhC, or that they will require close collaboration and partnership working with other regulators and stakeholders to succeed. For example, one pharmacy organisation referenced the recent consultation of the Department of Health and Social Care on regulatory reform, noting that our EDI work should be cognisant of the proposed changes.

The introductory 'Words matter' section of the consultation document was well received, particularly in relation to the more nuanced approached described in the strategy about the limitations of the BAME acronym. The definitions of key words and phrases were welcomed as a good starting point to the

conversation. A number of respondents throughout the consultation suggested other words and phrases that might also be helpfully defined in this section, whereas others suggested minor edits, and some additions and/or minor changes related to some of the wording across the three themes.

Some respondents pointed out what they felt were specific gaps, for example, several stakeholders felt that aspects of the strategy were 'community pharmacy focused' and that we should consider how we can play a role in supporting pharmacy professionals who do not work in environments regulated by the GPhC. Others encouraged us to make sure that the strategy, and any associated work, recognises the distinct roles of pharmacists and pharmacy technicians, and the different strengths of the two professions.

A number of respondents, including both individuals and organisations, felt that outcomes could be more prescriptive and expected the strategy, at this stage, to expand on success measures and clarify how progress will be demonstrated and evidenced. On the other hand, a few stakeholders recognised the high-level and strategic nature of the document and that an action plan will follow to support implementation as the wok in this area progresses. For example, one stakeholder commented that the outcome statements are, by definition of being strategic, high level and do not include specific measures, and that the relationship between the strategic objectives and outcomes is therefore appropriate. Some respondents felt that, overall, the outcomes across all three themes, were appropriate, but suggested minor edits to the drafting.

Several respondents specifically supported the enhanced governance arrangements described in the strategy, including the need to monitor and evaluate impact, with findings shared externally and in an open and transparent way. A small number of stakeholders in the pharmacy sector felt that there should be external representation on the EDI Strategy Leadership Group, whereas patients and the public, or organisations representing those groups, did not specifically raise this point through the consultation or other engagement activities.

Analysis by survey question

In the section below of the report, the tables show the detailed level of agreement/disagreement of respondents to our survey questions.

In each column, the number of respondents ('N') and their percentage ('%') is shown. The last column in each table captures the views of all survey respondents ('Total N and %').

The responses of individuals and organisations are also shown separately to enable any trends to be identified.

1. Theme 1: To make regulatory decisions that are demonstrably fair, lawful and so free from discrimination and bias

Table 1: Views on Theme 1

Q12: To what extent do you agree or disagree that Theme 1 is appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	110 (44%)	5 (23%)	115 (42%)
Agree	98 (39%)	14 (64%)	112 (41%)
Neither agree nor disagree	21 (8%)	2 (9%)	23 (8%)
Disagree	7 (3%)	0 (0%)	7 (3%)
Strongly disagree	8 (3%)	0 (0%)	8 (3%)
Don't know	6 (2%)	1 (5%)	7 (3%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 1 shows that a substantial majority of all respondents (83%) either agreed or strongly agreed that Theme 1 is appropriate. Levels of agreement were broadly similar between individuals (83%) and organisations (87%). In contrast, a very small percentage of individual respondents (6%) either disagreed or strongly disagreed with Theme 1. No organisations disagreed with our proposals. A modest percentage of all respondents (11%) indicated that they neither agreed nor disagreed with Theme 1, or they didn't know.

Table 2: Views on objectives under Theme 1

Q13: There are seven objectives under Theme 1. To what extent do you agree or disagree that the objectives under Theme 1 are appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	67 (27%)	4 (18%)	71 (26%)
Agree	128 (51%)	15 (68%)	143 (53%)
Neither agree nor disagree	32 (13%)	2 (9%)	34 (13%)
Disagree	10 (4%)	0 (0%)	10 (4%)
Strongly disagree	9 (4%)	0 (0%)	9 (3%)
Don't know	4 (2%)	1 (5%)	5 (2%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 2 shows that a large majority of all respondents (79%) either agreed or strongly agreed that the seven objectives under Theme 1 are appropriate. Agreement was higher amongst organisations (86%) than amongst individuals (78%). In contrast, a very small percentage of individual respondents (7%) either disagreed or strongly disagreed with the seven objectives under Theme 1 and no organisations disagreed with our proposals. A modest percentage of all respondents (15%) indicated that they neither agreed nor disagreed with the seven objectives under Theme 1, or they didn't know.

Table 3: Views on outcomes under Theme 1

Q14: There are four strategic outcomes under Theme 1. To what extent do you agree or disagree that the strategic outcomes under Theme 1 are appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	63 (25%)	4 (18%)	67 (25%)
Agree	128 (51%)	15 (68%)	143 (53%)
Neither agree nor disagree	36 (14%)	2 (9%)	38 (14%)
Disagree	10 (4%)	0 (0%)	10 (4%)
Strongly disagree	8 (3%)	0 (0%)	8 (3%)
Don't know	5 (2%)	1 (5%)	6 (2%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 3 shows that a large majority of all respondents (78%) either agreed or strongly agreed that the four strategic outcomes under Theme 1 are appropriate. Agreement was higher amongst organisations (86%) than amongst individuals (76%). In contrast, a very small percentage of individual respondents (7%) either disagreed or strongly disagreed with the four strategic outcomes under Theme 1 and no organisations disagreed with our proposals. A modest percentage of all respondents (16%) indicated that they neither agreed nor disagreed with the four strategic outcomes under Theme 1, or they didn't know.

1.1 Summary of points raised

Most respondents who agreed or strongly agreed with the proposals across all three themes did not provide detailed comments or views. This trend can be seen clearly within Theme 1.

As can be seen in the analysis above, the large majority of respondents agreed with Theme 1, and its objectives and outcomes.

Only one fifth (approximately) of all respondents left explanatory comments across the three questions about to Theme 1.

The following is an analysis of the points raised in those comments, as well as the observations and feedback provided during the wider engagement events. Broadly speaking, the comments and feedback made in relation to Theme 1 fell into the following areas in order of prevalence:

- General support and/or support for specific elements of the strategy
- Request for clarification or further information
- Difficulty and challenges in measuring or demonstrating success
- Concern about EDI in societal terms and/or its role in regulation
- Diversity and training of decision-makers
- Need for anonymisation in decision-making
- Improving our use of data
- Understanding and responding to existing bias
- Working collaboratively with others
- Other comments

1.2 General support and/or support for specific elements of the strategy

Many respondents provided wider comments in support of our proposals. Whilst agreeing with our approach, not all comments related to specific aspects of the proposals and instead were more general in nature.

Examples included agreement that this was the right direction for the GPhC, comments that the approach was appropriate, and those agreeing that Theme 1 was an improvement on what currently existed. Comments in support of specific aspects of the strategy were largely in relation to our commitment to have a proactive response to EDI. There was, for example, a strong positive response to the emphasis on the use of data in this Theme, as a means to secure greater transparency of outcomes in FtP cases.

1.3 Request for clarification or further information

Of those leaving comments, many respondents sought further clarification on aspects of our proposals or requested additional information that had not been included in the consultation paper.

Examples included:

- asking for clarity on the process that will be used to collect, analyse and publish EDI data about fitness to practise cases, how regularly this will be published, and how we will use data to monitor and address any disproportionality.
- asking what steps we are taking to ensure that we tackle risks of bias in the fitness to practise process.
- the need for more clarity in relation to our approach to tackling the disproportionate numbers of concerns received about Black, Asian and minority ethnic pharmacy professionals and an objective analysis of this going forward.

- asking how the outcome of greater stakeholder and staff confidence is intended to be measured.
- querying whether a continuous cycle of reflection would be used to secure progress.

Some of these issues have been elaborated on in the following sections.

1.4 Difficulty and challenges in measuring or demonstrating success

A common issue raised by those respondents who provided detailed comments about Theme 1 was in relation to the challenges and difficulties in measuring or demonstrating success, including questions about how we will measure progress in this area. Many of these respondents agreed with the overall approach, but queried how achievement would be evidenced.

Some specific queries included:

- how we will measure the effectiveness of training to enable staff to make unbiased decisions.
- what other measures, apart from training, we will consider achieving the outcomes under Theme 1 in order to respect 'lived experience'
- asking how we will review and monitor staff EDI confidence and capability in making regulatory decisions.
- welcoming the enhanced use of data but asking how we intend to use this to support our approach.
- suggesting that we make sure that our operational procedures enable us to anonymise decision making wherever possible (this is discussed in more detail below)

1.5 Concern about EDI in societal terms and/or its role in regulation

A few respondents disagreed with our proposals and expressed this in the form of personal disaccord with EDI in societal terms, including their personal views on the scale or prevalence of discrimination or prejudice in contemporary Great Britain, as well as the role of EDI in pharmacy regulation.

In this context, a very small number of respondents raised concern about our proposed use of positive action measures to alleviate disadvantage or under-representation within our workforce (which is lawful under the Equality Act 2010). They appeared to confuse this with positive discrimination, which is the act of treating someone more favourably because of a protected characteristic and is generally unlawful under the Equality Act 2010 unless a statutory exception applies.

1.6 Diversity and training of decision makers

Many respondents talked about the importance of diversity within those making decisions, including Fitness to Practise staff and statutory committees. Others suggested that the fundamental point is that decision-makers are able, through unconscious bias training, observation, and appraisal, and that they understand and uphold the requirements of the Equality Act, the strategy and associated guidance

Many respondents supported the need for appropriate, bespoke training for decision–makers, specifically within the Fitness to Practice Directorate. Some respondents discussed the importance of

sourcing the right expert advice and training, and that this is acted on consistently, specifically in the context of hearings.

Several respondents cross referenced the recent Managing Concerns Strategy in their responses to Theme 1 and the link to unbiased decision making, triage processes, training and measuring impact.

1.7 Need for anonymisation in decision-making

Many respondents were supportive of initiatives to mitigate the risk of bias such as anonymous decision-making. Although the strategy discussed the planned anonymous decision-making pilot of cases at the Investigating Committee stage, many respondents wanted to see specific proposals for anonymisation (removal of personal data and protected characteristic information) at other key decision-making stages, including the initial investigation stage (unless relevant to the concern under consideration).

Some felt this would support efforts to create a culture that removes prejudice and bias and ensures non-discriminatory decision making, while others felt this would be the only way to eliminate the risk of bias based on protected characteristics.

1.8 Improving our use of data

Many respondents were supportive of the greater use of data to understand fitness to practise outcomes and help shape appropriate anti-discrimination initiatives. However, some respondents also highlighted that data only goes so far. Some discussed the importance of collecting data to truly understand the pharmacy workforce, and the need to ensure that this is handled safely and securely

Several respondents recognised the close connection between Theme 1, data and evidence-based approach to EDI, and how this secures public trust and confidence.

Some commented on the importance of acting and reporting on the data, to demonstrate credibility whilst other respondents commented on the need to ensure that we maintain an intersectional approach to data analysis.

1.9 Understanding and responding to existing bias

In commenting on Theme 1, many respondents discussed the disproportionate numbers of concerns received about Black, Asian and minority ethnic healthcare professionals across the different sectors, including pharmacy.

Some said that until this variation is fully understood and articulated, then it is unlikely that the GPhC's regulatory decisions and processes will be seen as being free from discrimination and bias.

At the same time, some respondents, including the public, felt that there may be wider population-based factors outside the control of the GPhC. A few respondents commented on the fact that there are inequalities in society, including risk of bias from patients/pharmacy users.

Several respondents, primarily during the discussions at the focus groups, were interested to know if the GPhC has any information about the diversity profile of those raising complaints, although they were unsure if this information would help address the issue or identify the right interventions for the future.

Most of the respondents who raised this issue felt that the GPhC should do more work to understand the reasons for this in the first instance and some said that they would like to see more concrete proposals on how we will do this.

Some respondents felt that the GPhC should commission formal research to develop greater understanding about the barriers people face within the process and, in turn, drive the right changes within the Fitness to Practise process. A few felt that, if needed, this work should be prioritised above other areas set out in the strategy as it is of significant importance.

1.10 Working collaboratively with others

A number of respondents highlighted the importance of the GPhC working with other organisations facing similar challenges and to learn and adopt best practices. For example, one organisation felt reassured that the GPhC plays an active part of the inter-regulatory inclusion and diversity forum, across the wider health and social care sector. Another example cited here included the research undertaken by the General Medical Council to look at how bias can be addressed in the Fitness to Practise process.

Some highlighted comparisons with other professions responding to similar challenges and discussed recent statistics or research that they have considered in other sectors.

1.11 Other comments

A few respondents agreed with the strategy proposal about the limitations of the BAME acronym. They felt that it is not helpful as this is too generic and the groupings can serve to mask specific disparities within different groups. Furthermore, this is a term that has received much criticism in recent discourse and in the external context.

A number of respondents had views on the use of the word 'so' in the context on Theme 1 – specifically that the word suggests a non sequitur and it possible that a decision that, on its face, is lawful, may nevertheless involve discrimination and/or bias. Some felt the word "so" should be replaced by "and".

Some respondents highlighted the need for regulatory processes to include recognition of cultural factors. For example, one organisation highlighted that to be fair to everyone, regulators need to consider the variances in cultural expressions of regret, and the shame that an investigation can raise in some communities. If not, healthcare professionals may be deemed to have no insight and decision makers may conclude that these professionals' fitness to practise is impaired. There was specific reference to the Medical Tribunal Practitioners Service (MPTS) guidance on how cultural differences and factors should be considered by decision-making panels as an example of good practice.

One organisation discussed the recent Professional Standards Authority appeal against the GPhC's Fitness to Practise Committee decision in the case of Ali and importance and relevance of adopting and applying resources such as the International Holocaust Remembrance Alliance's definition of antisemitism.

2 Theme 2: To use our standards to proactively help tackle discrimination in all pharmacy settings and to make sure everyone can access person centred care, fostering equality of health outcomes

Table 4: Views on Theme 2

Q15: To what extent do you agree or disagree that Theme 2 is appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	95 (38%)	6 (27%)	101 (37%)
Agree	105 (42%)	12 (55%)	117 (43%)
Neither agree nor disagree	23 (9%)	2 (9%)	25 (9%)
Disagree	12 (5%)	2 (9%)	14 (5%)
Strongly disagree	9 (4%)	0 (0%)	9 (3%)
Don't know	6 (2%)	0 (0%)	6 (2%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 4 shows that a substantial majority of all respondents (**80%**) either agreed or strongly agreed that Theme 2 is appropriate. In contrast, a very small percentage of all respondents (8%) either disagreed or strongly disagreed with Theme 2. Levels of agreement and disagreement were very similar amongst individuals and organisations. A modest percentage of all respondents (11%) indicated that they neither agreed nor disagreed with Theme 2, or they didn't know.

Table 5: Views on objectives under Theme 2

Q16: There are six objectives under Theme 2. To what extent do you agree or disagree that the objectives under Theme 2 are appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	73 (29%)	3 (14%)	76 (28%)
Agree	121 (48%)	14 (64%)	135 (50%)
Neither agree nor disagree	32 (13%)	3 (14%)	35 (13%)
Disagree	12 (5%)	1 (5%)	13 (5%)
Strongly disagree	8 (3%)	0 (0%)	8 (3%)
Don't know	4 (2%)	1 (5%)	5 (2%)

Q16: There are six objectives under Theme 2. To what extent do you agree or disagree that the objectives under Theme 2 are appropriate?	N and % individuals	N and % organisations	N and % Total
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 5 shows that a large majority of all respondents (78%) either agreed or strongly agreed that the six objectives under Theme 2 are appropriate. In contrast, a very small percentage of all respondents (8%) either disagreed or strongly disagreed with the six objectives under Theme 2. Levels of agreement were similar amongst individuals (77%) and organisations (78%) and slightly more individuals strongly disagreed than organisations (3% compared with 0%). A modest percentage of all respondents (15%) indicated that they neither agreed nor disagreed with the six objectives under Theme 2, or they didn't know.

Table 6: Views on outcomes under Theme 2

Q17: There are four strategic outcomes under Theme 2. To what extent do you agree or disagree that the strategic outcomes under Theme 2 are appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	73 (29%)	3 (14%)	76 (28%)
Agree	116 (46%)	14 (64%)	130 (48%)
Neither agree nor disagree	33 (13%)	3 (14%)	36 (13%)
Disagree	14 (6%)	1 (5%)	15 (6%)
Strongly disagree	9 (4%)	0 (0%)	9 (3%)
Don't know	5 (2%)	1 (5%)	6 (2%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 6 shows that a large majority of all respondents (76%) either agreed or strongly agreed that the four strategic outcomes under Theme 2 are appropriate. In contrast, a very small percentage of all respondents (9%) either disagreed or strongly disagreed with the four strategic outcomes under Theme 2. There were similar levels of agreement amongst individuals and organisation, however, slightly more individuals either disagreed or strongly disagreed (10%) than did organisations (5%). A modest percentage of all respondents (15%) indicated that they neither agreed nor disagreed with the four objectives under Theme 2, or they didn't know.

2.1 Summary of points raised

Most respondents who agreed or strongly agreed with the proposals across all three themes did not provide detailed comments or views. This trend can also be seen clearly within Theme 2.

As can be seen in the analysis above, the large majority of respondents agreed with Theme 2, and its objectives and outcomes.

Only one fifth (approximately) of all respondents left explanatory comments across the three questions pertaining to Theme 2.

The following is an analysis of the points raised in those comments, as well as the observations and feedback provided during the wider engagement events.

Of the comments and feedback provided about Theme 2, these were in the following order of prevalence:

- General support
- Perceived gaps or changes to wording
- Other suggestions for implementation
- Support for the Equality Guidance for Pharmacy Owners
- Supporting pharmacy teams to speak up and challenge discrimination
- Improving person-centred care

2.2 General Support

Overall, as can be seen in Table 4 most respondents welcomed and supported Theme 2. In providing their feedback, many expressed their overall support for Theme 2 and its renewed commitment to be more proactive in using our Standards to help tackle discrimination in all pharmacy settings, and to make sure everyone can access person-centred care, fostering equality in health outcomes.

2.3 Perceived gaps or changes to wording

Respondents also shared ideas for how the wording and language under Theme 2 could be improved, including:

- Some respondents had specific views and comments about the phrase “all pharmacy settings” in Theme 2. Some felt that, for absolute clarity, this should explicitly mention education and training settings.
- Others felt that this could be changed to wording such as “all environments where pharmacy professionals deliver services”, to future proof the strategy and reflect the changing nature of pharmacy roles and working environments.
- Others felt that should simply refer to “all settings”, to avoid any disconnect with our Standards for Pharmacy Professionals, which need to be “met at all times, not only during working hours.”
- One pharmacy organisation said that the GPhC should make it explicit to registrants, through this work and any associated policy or guidance, that any actions that abuse, denigrate or

threaten others on the grounds of protected characteristics will be regarded as a prima facie breach of the GPhC's standards.

2.4 Other suggestions for implementation

Some respondents made other suggestions about how we could implement the strategy, including:

- Some respondents felt that the GPhC should consider including EDI in the revalidation processes for pharmacy professionals even though this was nor proposed in the strategy itself. For example, by encouraging this as part of the peer discussion, CPD record or reflective account.
- Another example was that the GPhC should specify a periodic requirement for an EDI related CPD record, which concentrates solely on the pharmacy member demonstrating CPD in EDI to improved patient care or a self- reflection
- Some respondents suggested that registration, revalidation and CPD should include an assessment of demonstrating an understanding of inclusive pharmacy
- On the other hand, a small number of respondents specifically commented that they would disagree with EDI being part of the revalidation process.

2.5 Support for the Equality Guidance for Pharmacy Owners

There was strong support for the proposal to develop comprehensive equality guidance for pharmacy owners, with many respondents recognising how this could support the delivery of this theme itself.

Some respondents suggested that there should be an emphasis within our Standards for Registered Pharmacies on ensuring that pharmacy owners/employers are creating open and inclusive environments, to support patients, the public and their employees, and that the proposed equality guidance could support this.

Some respondents felt that clear guidance will help equip pharmacy teams with the knowledge and confidence to tackle discrimination, but that this guidance must also be embedded into everyday practice. Others discussed the need for the equality guidance to provide practical advice and guidance that pharmacy professionals can apply to their everyday work.

A number of respondents specifically welcomed the development of practical equality guidance so that they would be better able to understand what good inclusive pharmacy looks like. Several respondents suggested that examples of good practice on inclusive pharmacy would be welcome.

Several respondents noted that our approach should recognise the different cultures within diverse pharmacy settings so that this can be better reflected in our equality guidance.

Some felt the equality guidance for pharmacy owners, linked to our standards for registered pharmacies, could help create the right environments in community pharmacy. But, there were some concerns about disparity for those working in environments that are not regulated by or under the jurisdiction of the GPhC such as GP practices, or hospital settings.

Other respondents highlighted that any new guidance should also be made available to all pharmacy teams, including pharmacy managers, area managers, head office staff as well as other staff.

One respondent suggested that the equality guidance should include references/ signposting to third sector/ not for profit organisations that could offer support/ help/ courses to registrants

2.6 Supporting pharmacy teams to speak up and challenge discrimination

Many respondents agreed with the commitment under Theme 2 to support pharmacy professionals and pharmacy teams to speak up and challenge discrimination, using our Standards and guidance to help them do that. Some respondents discussed how difficult and challenging it can be for those trying to raise concerns within the workplace, and some shared anonymous experiences of having faced discrimination by employers or colleagues.

One pharmacy organisation said that in their experience Black, Asian and minority ethnic members of staff are not comfortable raising these issues, even within their workplace. This organisation said there are cases of lack of support with senior management when issues have been escalated within the organisation. This will be a challenge to overcome and requires a proactive approach by the GPhC, to encourage individuals who share protected characteristics to come forward and report.

We heard about options for how the GPhC could work with employers to raise awareness of what a supportive and confidential pathway could look like and how those raising concerns about discrimination could be supported. This included communications tools such as webinars or short video content. Some felt that clear, practical guidance from the regulator and the use standards will support pharmacy teams to speak up and challenge discrimination.

We also heard about the importance of education and training providers ensuring that their training programmes equip students, from the beginning of their careers, with the confidence to have right conversations and challenge discrimination.

2.7 Improving person-centred care

We heard about the importance of using our regulatory tools such as our Standards to make sure that patients are treated fairly and with respect in pharmacy settings.

We also heard that supporting pharmacy professionals and pharmacy teams to educate themselves and their teams, encouraging them to be curious and open to learning about different cultures is essential for person-centred care. This included the importance of supporting professionals to provide services in ways that are culturally sensitive with greater confidence.

Some respondents felt that the public and other stakeholders will also benefit from the assurances that they will be able to seek pharmacy services and advice free of discrimination.

a. Patient voice and other resources

We also heard about the important of patient voice and user experience, to truly understand what discrimination and prejudice looks like, and how we can use our standards to tackle this.

There was also support for co-production and working with others to produce practical resources. We heard about the importance of partnering or collaborating with relevant organisations, who can support with audience insights, particularly where we do not hold data on those specific groups ourselves

Most respondents were supportive of using our Knowledge Hub, to promote and share examples of notable EDI practice that our inspectors have identified through our inspection processes, to support continuous learning and improvement in the sector.

One respondent said that the notable practice examples shared during the Covid-19 pandemic were "invaluable" for registrants and businesses and expressed interest in seeing how EDI examples could be shared, specifically given what they described as the "challenges and complexities" of the issues.

Some respondents highlighted the need to raise more awareness about the Knowledge Hub, where and how to find the information, and to consider periodic or standalone updates for the sector to shine a light on this work.

A small number of respondents highlighted that the Knowledge Hub focusses primarily on the Standards for Registered Pharmacies and the information that we gather through our inspection processes. It was suggested that consideration could be given to how we raise awareness of good practice relating to our Standards for Pharmacy Professionals, or examples of good practice that don't relate to those working in registered pharmacies.

A few respondents also felt the GPhC could do more to share examples of good EDI practice in the education and training, including how providers have built this into their curricula and academic culture

One respondent highlighted how differing national policy approaches across Great Britain can impact on equality of health outcomes and how we should be alive to this, even where some issues may be directly outside of our remit.

b. Barriers to person-centred care

Some respondents gave examples of other broader issues that could potentially be addressed through our Standards and our communication tools such as increased awareness of neurodiversity, insights into mental health awareness, or information about ways to overcome barriers, to provide truly person-centred care.

In our patient and public focus groups, we also heard first-hand about the barriers to person-centred care. Attendees shared examples of when they have received person-centred care from a pharmacist, pharmacy technician or pharmacy team member, and how this made them feel, and there were many positive examples. They also shared ideas and suggestions about how the GPhC and the pharmacy sector could do more to support person-centred care that recognises the diverse needs and cultural differences of the communities they serve. These examples went beyond considerations of the nine protected characteristics and included the following:

- The importance of lived experiences and diverse patient stories, incorporating as many viewpoints as possible, especially those that may typically face unseen barriers
- The need for professionals and regulators to understand and respond to the needs of the people and the communities they serve
- The importance of intersectionality – pharmacists and pharmacy technicians should be thinking about how different aspects of someone's identity come together to influence the way they should be treated
- The importance of having a holistic approach – seeing the 'whole' person
- The need to consider carers and other people providing support or advocacy for patients, who can sometimes be overlooked
- The need to encourage diverse and inclusive healthcare settings and to embed a person-centred and inclusive approach right from the beginning of a professional's career journey

- How our inspection regime should take account of EDI issues, including how we approach this through the eyes of a patient with different needs or challenges
- The need to support patients with language or other communication barriers, and to be better equipped to deal with hidden or invisible disabilities (we discuss language in more detail below)
- How to support and maintain a person-centred approach and manage issues such as privacy and confidentiality in the context of Covid-19 secure measures. For example, where physical barriers and screens can result in loud conversation about sensitive health matters.
- Through the consultation, we also heard from a number of different equalities focused pharmacy networks, who shared insights and feedback from their members on a range of different intersectional issues, for example:
- We heard that heteronormative and cis-normative attitudes towards healthcare still exist within the pharmacy world and are contributing to a rise in health inequalities for the LGBT+ community.
- We heard that assumptions and attitudes towards sexuality and gender can still hinder patient care.
- We heard that education and training establishments need to play a part in teaching aspiring healthcare professionals about LGBT+ health issues and gender inclusivity, and the GPhC has a responsibility to ensure this happens.
- We heard that a particular issue for LGBT+ people is the lack of data collection with regards to sexual orientation and gender identity, and how this can be a barrier to implementing meaningful improvements to equality, diversity, and inclusion.
- We heard about network member views on issues around the absence of appropriate facilities in community pharmacies, as well as a lack of suitable training within pharmacy as a profession, and about negative experiences in workplaces and how attitudes to disability need to change.

c. Language and communication barriers

Several respondents discussed the importance of language and how the strategy should be accessible in different formats, including the use of pictograms to aid people with learning disabilities, those who are neuro diverse, or speakers of other languages.

In particular, we heard specifically from several respondents about health literacy, language and communication barriers and how these can embed or contribute to discrimination.

These respondents told us that language barriers have been identified as the biggest obstacles in providing adequate, appropriate, effective and timely care to patients with limited English proficiency. And we heard that those with limited proficiency in English skills can experience worse clinical outcomes and systemic lower quality of care.

We also heard that miscommunication is a central factor in medication safety issues, and about the link between language barriers and poor adherence to prescribed medicines, as highlighted through academic research on this issue referenced in the response. These respondents also told us about how there can be other barriers: for example, the issues with lack of translation services, patients relying solely on carers or accompanying family or friends for support, with patients forgoing their right to

confidentiality and children having to interpret complex, sensitive and inappropriate information or how the use of informal words and culturally taboo topics can cause further unintended barriers.

We heard that technology is already used to improve how the pharmacy workforce functions, its clinical workflows, professional practice efficiencies and service-user experience. However, these respondents felt that the same progress has not been reflected in the form of personalised medication information accessibility for those with communication and language barriers, at the point of prescribing to dispensing and beyond.

This group welcomed the development of comprehensive guidance for pharmacy owners, but told us that this should include robust guidance on the language needs of underserved or marginalised communities, including Black, Asian and minority ethnic communities.

These respondents made a number of recommendations for the GPhC to consider, for example, to be an active and vocal participant in reducing language and communication barriers; to promote health and medication information equity; to reference best practice from within pharmacy and other healthcare professional bodies; to engage with marginalised groups that have communication barriers and limited ability in English; to engage with innovators and technology providers to improve pharmacy practice; and to provide robust guidance for interpreting and translating in Welsh and other languages. However, there were also some recommendations that may be outside of our legal scope and remit, for example, to use our Standards to mandate the provision of specific technology solutions to meet these different needs.

3 Theme 3: To lead by example and demonstrate best practice within our organisation, holding ourselves to the same standards we expect of others

Table 7: Views on Theme 3

Q18: To what extent do you agree or disagree that Theme 3 is appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	101 (40%)	6 (27%)	107 (39%)
Agree	107 (43%)	10 (45%)	117 (43%)
Neither agree nor disagree	19 (8%)	2 (9%)	21 (8%)
Disagree	9 (4%)	2 (9%)	11 (4%)
Strongly disagree	9 (4%)	0 (0%)	9 (3%)
Don't know	5 (2%)	2 (9%)	7 (3%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 7 shows that a substantial majority of all respondents (**82%**) either agreed or strongly agreed that Theme 3 is appropriate. Levels of agreement were higher amongst individuals (83%) compared with organisations (72%). In contrast, a very small percentage of all respondents (7%) either disagreed or strongly disagreed with Theme 3. A modest percentage of all respondents (11%) indicated that they neither agreed nor disagreed with Theme 3, or they didn't know.

Table 8: Views on objectives under Theme 3

Q19: There are eleven objectives under Theme 3. To what extent do you agree or disagree that the objectives under Theme 3 are appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	84 (34%)	3 (14%)	87 (32%)
Agree	114 (46%)	14 (64%)	128 (47%)
Neither agree nor disagree	26 (10%)	3 (14%)	29 (11%)
Disagree	12 (5%)	0 (0%)	12 (4%)
Strongly disagree	9 (4%)	1 (5%)	10 (4%)
Don't know	5 (2%)	1 (5%)	6 (2%)

Q19: There are eleven objectives under Theme 3. To what extent do you agree or disagree that the objectives under Theme 3 are appropriate?	N and % individuals	N and % organisations	N and % Total
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 8 shows that a large majority of all respondents (79%) either agreed or strongly agreed that the eleven objectives under Theme 3 are appropriate. Levels of agreement were very similar between individuals and organisations (80% and 78%). In contrast, a very small percentage of all respondents (8%) either disagreed or strongly disagreed with the eleven objectives under Theme 3. A modest percentage of all respondents (13%) indicated that they neither agreed nor disagreed with the eleven objectives under Theme 3, or they didn't know.

Table 9: Views on outcomes under Theme 3

Q20: There are five strategic outcomes under Theme 3. To what extent do you agree or disagree that the strategic outcomes under Theme 3 are appropriate?	N and % individuals	N and % organisations	N and % Total
Strongly agree	74 (30%)	4 (18%)	78 (29%)
Agree	119 (48%)	13 (59%)	132 (49%)
Neither agree nor disagree	29 (12%)	2 (9%)	31 (11%)
Disagree	16 (6%)	2 (9%)	18 (7%)
Strongly disagree	8 (3%)	0 (0%)	8 (3%)
Don't know	4 (2%)	1 (5%)	5 (2%)
Total N of responses	**250 (100%)**	**22 (100%)**	**272 (100%)**

Table 9 shows that a large majority of all respondents (78%) either agreed or strongly agreed that the five strategic outcomes under Theme 3 are appropriate. In contrast, a very small percentage of all respondents (10%) either disagreed or strongly disagreed with the four strategic outcomes under Theme 2. The levels of agreement and disagreement were very similar amongst individuals and organisations. A modest percentage of all respondents (13%) indicated that they neither agreed nor disagreed with the four strategic outcomes under Theme 2, or they didn't know.

3.1 Summary of points raised

Most respondents who agreed or strongly agreed with the proposals across all three themes did not provide detailed comments or views. This trend can also be seen clearly within Theme 3.

As can be seen in the analysis above, the large majority of respondents agreed with Theme 3, and its objectives and outcomes.

Only one sixth (approximately) of all respondents left explanatory comments across the three questions about Theme 3.

The following is an analysis of the points raised in these comments, as well as the observations made during the wider engagement events.

Of the comments and feedback provided about Theme 3, these were in the following order of prevalence:

- General support
- Concern about EDI in societal terms and/or its role in regulation
- Request for clarification/more information
- Perceived gaps and/or other suggestions for implementation
- Difficulties and challenges in measuring or demonstrating success

The following is an analysis of the points raised in those comments, as well as the observations and feedback provided during the wider engagement events.

3.2 General Support

Overall, as can be seen in the tables above, a large majority of stakeholders found that Theme 3 is valid. The most common trend amongst respondents was to confirm their general support for Theme 3 and to reiterate that the proposed objectives and outcomes sitting under it are sound, comprehensive and appropriate. The greater internal commitment to EDI by the regulator to better frame delivery was overall welcome. Many respondents also supported the GPhC's desire to lead by example and ensure that it adheres to the same high standards expected of others.

3.3 Concern about EDI in societal terms and/or its role in regulation

As mentioned above, a few respondents disagreed with our proposals and expressed this in the form of personal disaccord with EDI in societal terms, including their personal views on the scale or prevalence of discrimination or prejudice in contemporary Great Britain, as well as the role of EDI in pharmacy regulation. These comments were also visible in relation to Theme 3.

And, as we highlighted above, a very small number of respondents raised concern about our proposed use positive action measures under Theme 3, to alleviate disadvantage or under-representation within our workforce (which is lawful under the Equality Act 2010). They appeared to confuse this with positive discrimination, which is the act of treating someone more favourably because of a protected characteristic and is generally unlawful under the Equality Act 2010 unless a statutory exception applies.

On the other hand, many respondents did not raise concerns about the reference to positive action, and one pharmacy organisation specifically supported this and suggested a small drafting change to the relevant section.

3.4 Request for clarification / more information

A small number of respondents felt that the term 'stakeholders' needs to be better defined to understand who the GPhC regards as such and to ensure that all parties, including patients and GPhC workforce, feel included in this term.

A number of respondents agreed that the GPhC, including senior leadership, and Council members and associates, should reflect the diversity of the public we serve and the professionals we regulate, and that proactive steps should be taken to support this through recruitment and retention processes, as well as positive action.

Several respondents felt that more data around the diversity profiles of our staff and associates involved in regulatory decisions should be shared or published, to boost the profession's confidence in our transparency and commitment to this area.

3.5 Perceived gaps and / or other suggestions for implementation

Several respondents and wider stakeholders welcomed and supported specific interventions outlined under the eleven objectives.

Overall, a few perceived gaps were highlighted and there were some suggestions for consideration at the implementation stage. These included:

- Several respondents really welcomed the approach of an internal EDI learning needs analysis to understand EDI knowledge gaps in our workforce and implement a co-ordinated plan to address these. One in particular asked whether EDI training would be mandatory and suggested that to be effective it should reflect the principles of CPD (continuing professional development), i.e. a cyclical approach that regularly informs action planning and personal reflection, and potentially further learning needs and action. It was argued that this will ultimately feed into an organisational culture where staff feel confident in considering EDI in their work and EDI becomes embedded practice.
- One organisation asked whether some staff training or resources, or aspects of training, could be shared with the wider sector, so they can also benefit from this. It was suggested this could encourage a 'culture of sharing' between all organisations who identify similar challenges with EDI in pharmacy.
- Across the consultation, and linked to the broader question of training, several respondents expressed an opinion that unconscious bias training is a good starting point, but organisations need a greater understanding of the nature of prejudice to move to a culture of inclusion.
- Linked to the points raised above about the diversity of our workforce, one respondent suggested that the GPhC should explore options for people to shadow or be mentored by Council members, to help create a pipeline and increase diversity in the future.
- Some respondents specifically welcomed the emphasis on lived experience to better inform our decision making, and several organisations in particular discussed the link with staff equality

networks. One individual respondent though was unclear about how lived experience will be taken into account and expressed some caution about how balanced views will be sought, without over-representing one-sided voices or opinions.

- A few respondents welcomed the proposal of EDI external benchmarking against other organisations to also support monitoring and reporting. At a stakeholder event, one person pointed out that specific schemes and benchmarking tend to leave other groups behind (for example race equality indexes hardly ever include Roma and gypsy communities), hence it would be better for the GPhC to look at more comprehensive EDI benchmarking.
- A few others suggested that the GPhC should consider publishing any pay gap action plans as well as pay gap reporting on areas beyond gender and ethnicity. One organisation said that the GPhC should carry out work to understand whether there is a ceiling on progression to senior roles and another suggested that the GPhC should play a role in publishing pay gap information about the professions it regulates (which may be outside of scope).
- Other examples were that the GPhC should consider mentoring programmes, to support the development of colleagues, which some pharmacy businesses are already doing.
- Another example was the GPhC makes a clear commitment to procure services from third-party companies that have robust and demonstrable EDI policies in place.

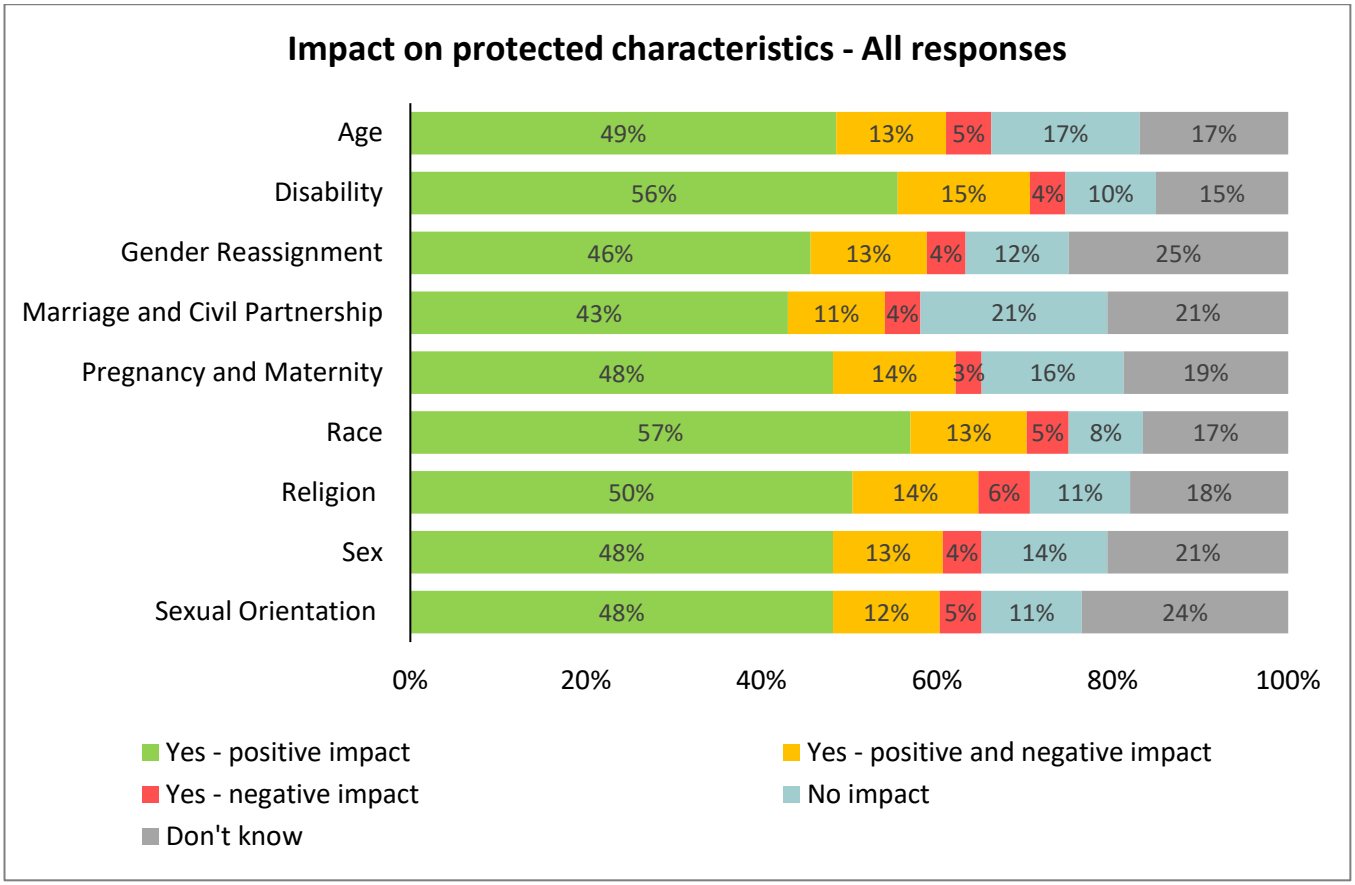
3.6 Difficulties and challenges in measuring or demonstrating success

In line with what also emerged from Themes 1, a number of respondents highlighted the challenges and difficulties in measuring or demonstrating success, including questions about how we will measure progress in this area. Many of these respondents agreed with the overall approach, but questioned about how achievement would be evidenced.

In particular, there was the view that progress on specific aspects such as ‘culture’ and ‘inclusion’ are hard to measure. As pointed out in the overview section, the nature of the draft proposal was high-level and an action plan will follow to support implementation as the work in this area progresses.

4 The impact of the proposed changes on people sharing particular protected characteristics

Figure 1: Views of all survey respondents (N = 272) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010



Most respondents (between 43% and 57%) believed that the proposals outlined in our strategy will have a positive impact on people sharing one or more of the nine protected characteristics.

Disability and race were the two characteristics which the largest number of respondents thought would be positively impacted (over 50%).

Marriage and civil partnership were the protected characteristic on which respondents most commonly thought there would be no impact (21%).

A small number of respondents (between 11% and 15%) thought the proposals might have both a positive and negative impact on each of the nine protected characteristics, whereas between 15% and 25% of respondents were not sure and answered that they did not know for each characteristic.

A minimal proportion of respondents thought that the proposals of our EDI Strategy will have a negative impact across all protected characteristics (between 4% and 6% of respondents).

A full breakdown of individual and organisational responses to this question is available below in figures 2 and 3. The breakdown highlights that it was mostly individual respondents who identified potential negative impact or no impact at all across all nine protected characteristics. On the other hand, organisations were slightly more optimistic about overall positive impact.

Breakdown of individual and organisational responses

Figure 2: Views of individual respondents (N = 250) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

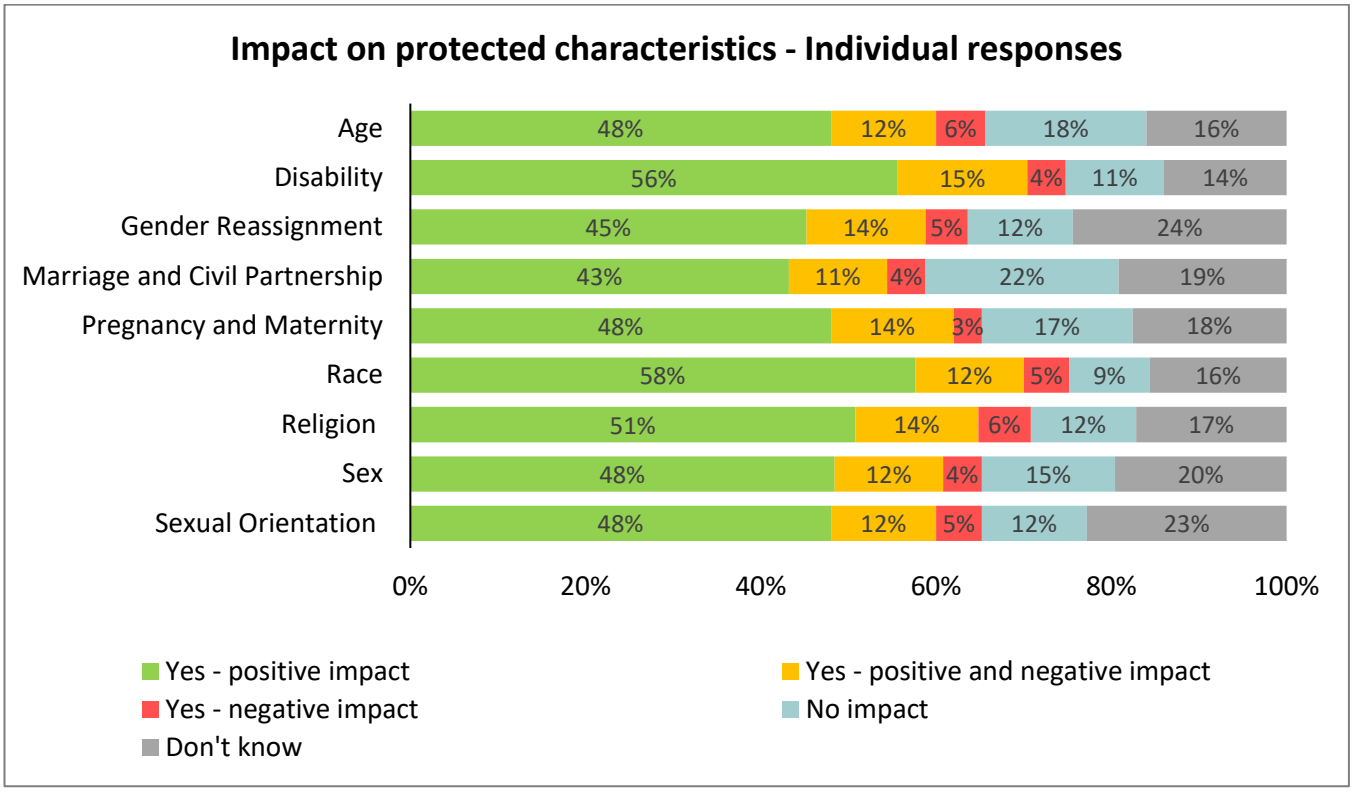
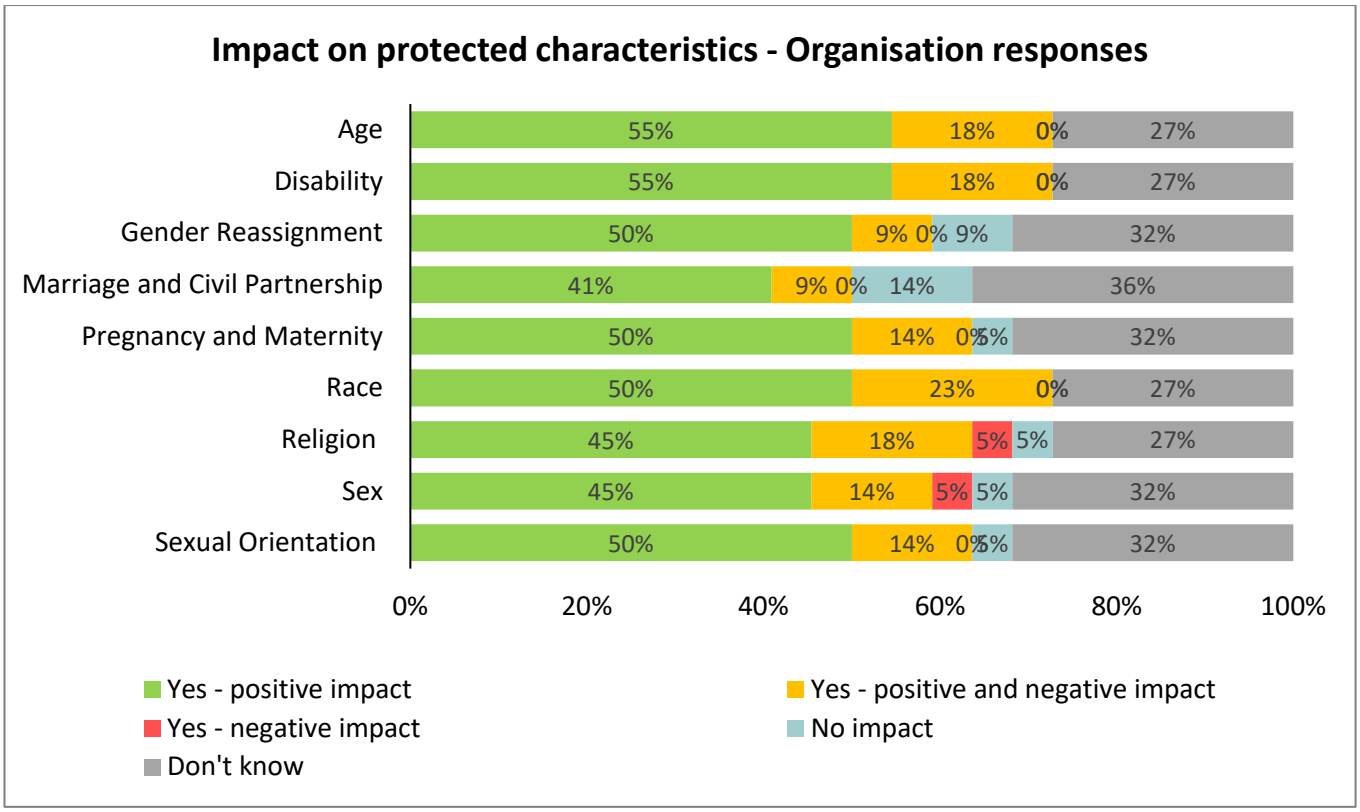


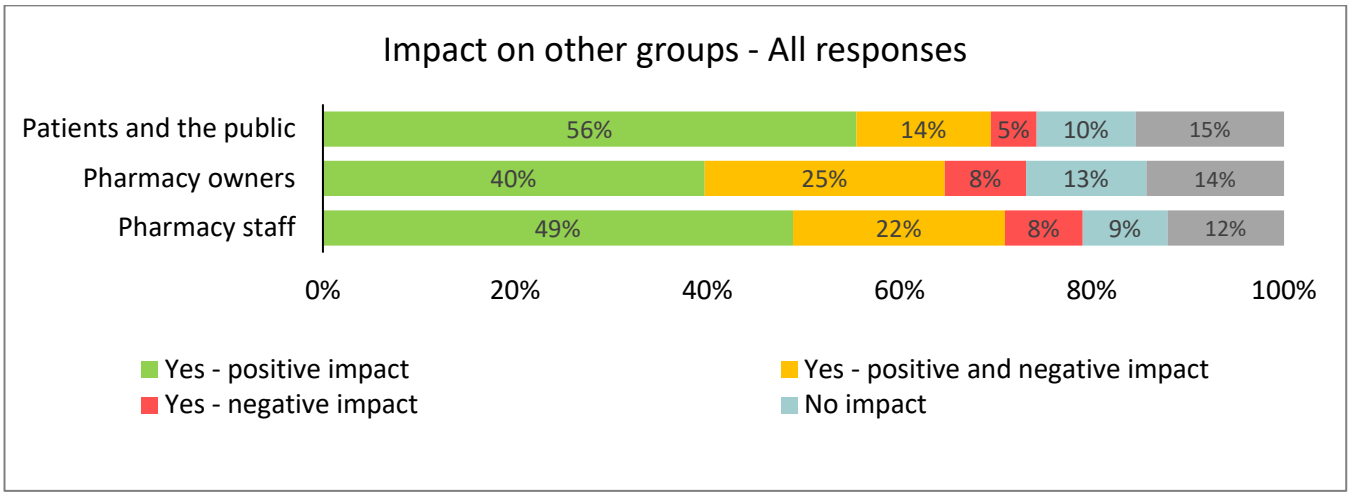
Figure 3: Views of organisations (N = 22) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010



5 The impact of the proposal on any other individuals or groups (not related to protected characteristics)

We also wanted to know if our proposals will have any other impact on any other individuals or groups (not related to protected characteristics), for example: patients, pharmacy owners or pharmacy staff.

Figure 4: Views of all survey respondents (N = 272) on the impact our proposals will have on any other individuals or groups



The largest proportion of respondents thought that our proposals would have a positive impact on other individuals or groups, particularly patients and the public (56%). A quarter felt that the proposals could have both a positive and negative impact on pharmacy owners. A minimal proportion of respondents (between 5% and 8%) thought that the proposals of our EDI Strategy will have a negative impact on all other individual and groups, whereas around a quarter responded that there will be no impact on each group, or they didn't know.

A full breakdown of individual and organisational responses to this question is available below.

The breakdown highlights that an almost identical proportion of individuals and organisations thought that our proposals will have a positive impact particularly on patients and the public. None of the organisations identified any negative impact. Organisations were also proportionally more optimistic about positive impact on pharmacy owners and pharmacy staff.

Breakdown of individual and organisational responses

Figure 5: Views of individual respondents (N = 250) on the impact our proposals will have on any other individuals or groups

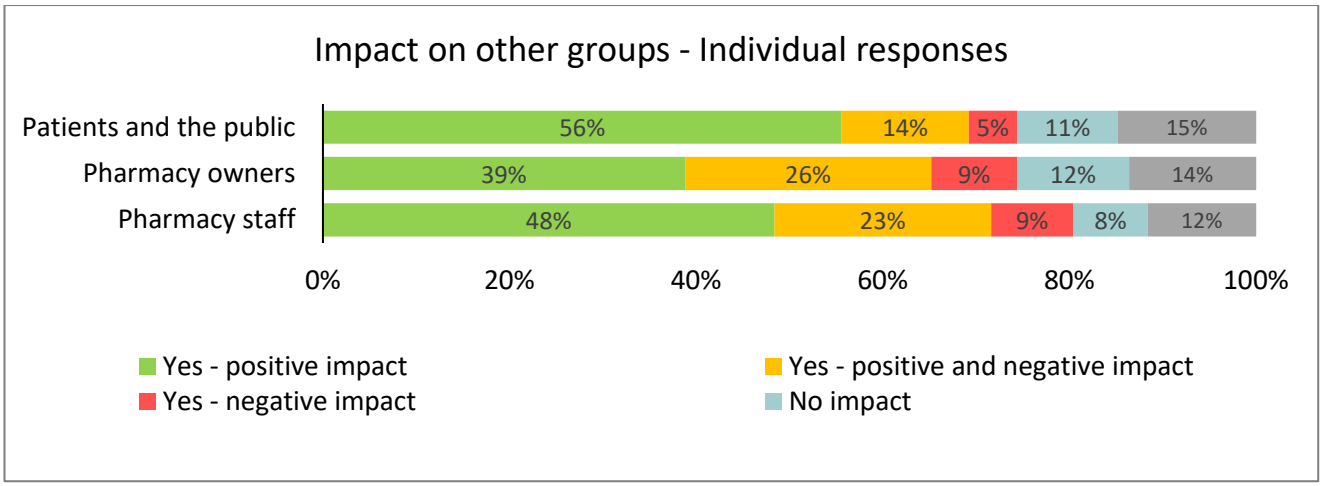
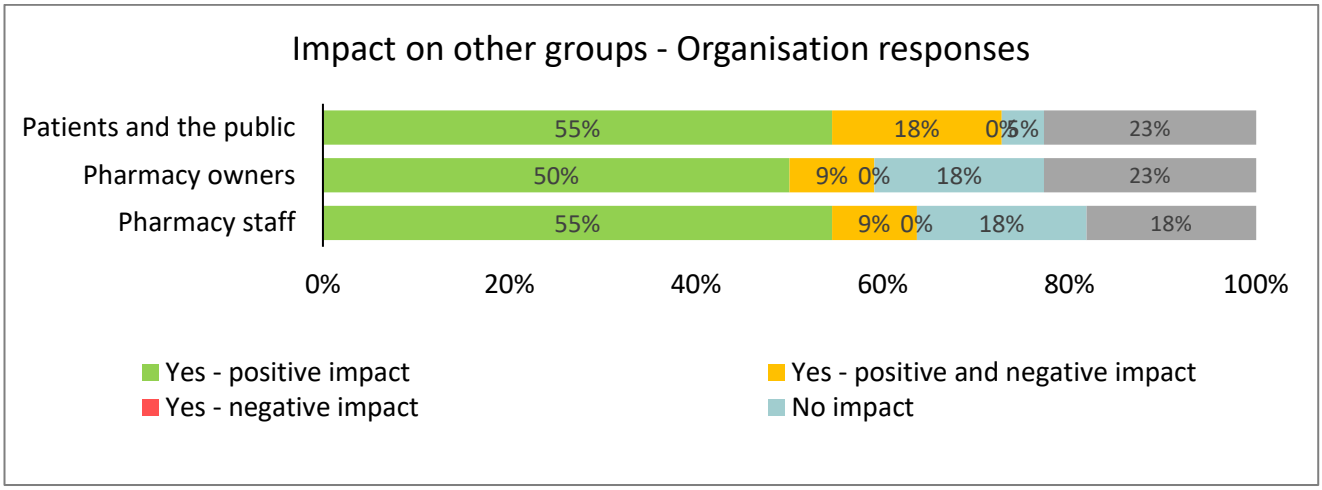


Figure 6: Views of organisations (N = 22) on the impact our proposals will have on any other individuals or groups



5.1 Summary of points raised

Around two fifths of all respondents left explanatory comments regarding the impact of the proposals.

The following is an analysis of the points raised in these comments, as well as the observations made during the wider engagement events.

As can be seen in the analysis above, the largest proportion of respondents agreed that the impact of the strategy would be positive. The main areas of impact, both positive and negative, were as follows:

5.2 Positive impact for patients

A number of respondents understood that a key underlying principle of our strategy is to secure a positive impact for patients and the public. Furthermore, there was agreement that patients, registrants and other stakeholders should all benefit from our stated approach.

Several respondents stated that they welcomed the development of the equality guidance in support of our standards as they felt that this would help to embed best practice and to develop an approach that was truly person centred. Some went on to say that this was important so that we could develop a more holistic approach that goes beyond the nine legally protected characteristics.

Some respondents reinforced the view that this would improve the patient experience, and that we should embed EDI into all our work so that this is not seen as an additional piece of work.

5.3 Positive impact for all

Another common theme amongst respondents was that this would have a positive impact for all, including patients, pharmacy owners and pharmacy staff.

Respondents agreed that the strategy would benefit everyone and would not be to the detriment of any groups. Some of these respondents whilst agreeing that everyone would benefit, did comment that the strategy could go even further to gain greater impact or benefits for these groups.

5.4 Positive impact on those sharing protected characteristics

As can be seen in the analysis above, the largest proportion of respondents agreed that the impact of the strategy would be positive across the protected characteristics, and there were very few responses which attracted comments in relation to any specific characteristic, as opposed to another.

Broadly speaking, the theme here was that we should ensure that our approach should ensure that we do not give prominence to any protected characteristic – that they should all be respected equally, not one to the detriment of another.

A small number of respondents included examples of where we could go further such as making sure that we include hidden disability in relation to any work that focuses on disability.

5.5 Negative Impact on pharmacy staff/teams

A number of individual respondents made comments expressing a view that this strategy would have a negative impact. These comments were predominantly expressed by individuals and ranged from those who clearly misunderstood the purpose of our strategy, thinking that we were adopting a position of positive discrimination; a feeling that this would increase the workload of pharmacy professionals, or that a focus on some protected characteristics would detract attention from others.

5.6 Other negative impacts

As mentioned throughout the analysis, few individual respondents made comments that demonstrated a lack of understanding of why this strategy matters to the work of the GPhC as a regulator and an employer, together with a concern that people could be labelled by one or more protected characteristic.

Appendix 1: Our approach to analysis and reporting

Overview

Every response received during the consultation period including notes from stakeholder events and one-to-ones meetings has been considered in the development of our analysis. 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.

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.

The purpose of the analysis was to identify common issues and observations amongst those involved in the consultation activities rather than to analyse the differences between specific groups or sub-groups of respondents.

The term 'respondents' used throughout the analysis refers to those who completed the consultation survey and those who attended our stakeholder events. It includes both individuals and organisations. Overall, there were no substantial differences between the views given in the consultation survey and those raised at stakeholder events.

Full details of the profile of respondents to the online survey is given in **Appendix 2**.

For transparency, **Appendix 3** provides a list of the organisations that have engaged in the consultation through the online survey, email responses their participation in our stakeholder events and/or one-to-one meetings. No organisation asked for their names to be withheld and kept confidential.

The consultation questions are provided in **Appendix 4**.

Quantitative analysis

The survey contained a number of quantitative questions such as strongly agree/strongly disagree questions and rating scales. All responses have been collated and analysed including those submitted by email or post using the consultation document. Those responding by post or email more generally about their views are captured under the qualitative analysis only.

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 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.

A small number (less than 10) 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 quantitative analysis, and all qualitative responses were analysed.

The tables contained within this analysis report present the number of respondents selecting different answers in response to questions in the survey. The ordering of all the questions in the survey has been followed in this analysis.

Percentages are shown without decimal places and have been rounded to the nearest whole number. As a result, some totals do not add up to 100%. This rounding also results in differences of up to one percentage point when combining two or more response categories. Figures of less than 1% are represented as <1%.

All questions were mandatory, and respondents had the option of selecting “don’t know” or “neither of agree nor disagree”. Routing was used where appropriate to enable respondents to skip questions that weren’t relevant. Skipped responses are not included in the tables for those questions.

Qualitative analysis

This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations, email responses, and notes of stakeholder engagement events and one-to-one meetings.

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 throughout the analysis process.

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

Prevalence of views was identified through detailed coding of written responses and analysis of feedback from stakeholder events and wider engagement using the themes from the coding framework.

The frequency with which views were expressed by respondents is indicated by the use of language such as ‘many’/’a large number/’, etc. to report the views with the most support amongst respondents. ‘Some’/’several’ indicate views shared by a smaller number of respondents and ‘few’/’a small number’ indicate issues raised by only a limited number of respondents. Terms such as ‘the majority’/’most’ are used if more than half of respondents held the same views. NB. This list of terms is not exhaustive and other similar terms are used throughout the narrative.

The consultation survey structure

The consultation survey was structured in such a way that open-ended questions followed each closed question or series of closed questions on the consultation proposals. This allowed people to explain their reasoning, provide examples and add further comments.

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 proposals. 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.

Appendix 2: Respondent profile: who we heard from

A series of introductory questions sought information on respondents' general location, and in what capacity they were responding to the survey. For organisational respondents, there were questions about the type of organisation that they worked for. The tables below present the breakdown of their responses. For individual respondents, questions were asked to specify whether they were pharmacists, pharmacy technicians, members of the public, or others.

Category of respondents

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

Are you responding: (Base: all respondents)	Total N	Total %
As an individual	250	92%
On behalf of an organisation	22	8%
Total N of responses answered	**272**	**100%**

Profile of individual respondents

Table 11: Countries

Where do you live? (Base: all individuals)	Total N	Total %
England	214	86%
Scotland	14	6%
Wales	10	4%
Northern Ireland	7	3%
Other	5	2%
Total N of responses	**250**	**100%**

Table 12: Respondent type

Are you responding as: (Base: all individuals)	Total N	Total %
A pharmacist	168	67%
A pharmacy technician	50	20%
A member of the public	24	10%
Other	8	3%
Total N of responses	**250**	**100%**

Table 13: Main area of work

Sector (Base: individuals excluding members of the public and other)	Total N	Total %
Community pharmacy (including online)	99	45%
Hospital pharmacy	57	26%
GP practice	16	7%
Research, education or training	14	6%
Primary care organisation	8	4%
Pharmaceutical industry	5	2%
Care home	2	1%
Prison pharmacy	2	1%
Other	15	7%
Total N of responses	**218**	**100%**

Table 14: Size of community pharmacy

Size of pharmacy chain (Base: individuals working in community pharmacy)	Total N	Total %
Independent pharmacy (1 pharmacy)	15	15%
Independent pharmacy chain (2-5 pharmacies)	11	11%
Small multiple pharmacy chain (6-25 pharmacies)	8	8%
Medium multiple pharmacy chain (26-100 pharmacies)	11	11%
Large multiple pharmacy chain (Over 100 pharmacies)	53	54%
Online-only pharmacy	1	1%
Total N of responses	**99**	**100%**

Profile of organisational respondents

Table 15: Type of organisation

Please choose the option below which best describes your organisation (Base: all organisations)	Total N	Total %
Organisation representing patients or the public	4	18%
Organisation representing pharmacy professionals or the pharmacy sector	8	36%
Registered pharmacy	5	23%
NHS organisation or group	2	9%

Please choose the option below which best describes your organisation (Base: all organisations)	Total N	Total %
Research, education or training organisation	1	5%
Other	2	9%
Total N of responses answered	**22**	**100%**

Table 16: Type of pharmacy

Please choose the option below which best describes your organisation (Base: all registered pharmacy organisations)	Total N	Total %
Independent pharmacy (1 pharmacy)	2	40%
Independent pharmacy chain (2-5 pharmacies)	1	20%
Large multiple pharmacy chain (over 100 pharmacies)	2	40%
Total N of responses	**5**	**100%**

Monitoring questions

Data was also 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). The monitoring questions were not linked to the consultation questions and 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.

Appendix 3: Organisations

The following organisations engaged in the consultation through the online survey, stakeholder engagement events, one-to-one meetings, and email responses. It should be noted that many of the below organisations welcomed the opportunity to engage in more than one way:

- Association of Pharmacy Technicians UK (APTUK)
- British Association of Physicians of Indian Origins (BAPIO)
- Cambridge University Hospitals NHS Foundation Trust
- Cardiff People First
- Cardiff University School of Pharmacy & Pharmaceutical Sciences
- Carers Trust
- Carters Chemists
- Chief Pharmaceutical Officer Scotland
- College of Mental Health Pharmacy (CMHP)
- Community Health Councils in Wales
- Community Pharmacy Wales
- Community Pharmacy Scotland
- Company Chemists Association
- Disability Rights UK
- Diverse Cymru
- Equalities and Human Rights Commission (EHRC)
- GenderGP
- Guild of Healthcare Pharmacists
- Health Education & Improvement Wales
- Health Education England
- Health Improvement Scotland
- Healthcare Inspectorate Wales
- Humanist UK
- Market Chemist
- McKesson UK
- Medical Information for Ethnic Minorities
- National LGBT Partnership

- National Pharmacy Association
- NHS Grampian
- NHS Race and Health Observatory
- Pharmacy Defence Association (PDA)
- PDA Ability Network
- PDA BAME Network
- PDA LGBT+ Network
- PDA National Association of Women Pharmacists
- Pharmacist Support
- Pharmacy Law and Ethics Association
- Pharmacy Technicians of Colour
- Rethink Mental Illness
- Rowlands Pharmacy
- Royal Pharmaceutical Society (RPS)
- RPS ABCD Group – Action in Belonging, Culture and Diversity
- Shivkai Ltd.T/A Leybourne Pharmacy
- SOCMED
- UK Black Pharmacist Association
- Written Medicine

Appendix 4: Consultation questions

Q1 To what extent do you agree or disagree that theme 1 is appropriate?

Q2 Please tell us if you have any views about theme 1.

Q3 There are seven objectives under theme 1. To what extent do you agree or disagree that the objectives under theme 1 are appropriate?

Q4 Please tell us if you have any views about the objectives under theme 1.

Q5 There are four strategic outcomes under theme 1. To what extent do you agree or disagree that the strategic outcomes under theme 1 are appropriate?

Q6 Please tell us if you have any views about the strategic outcomes under theme 1.

Q7 To what extent do you agree or disagree that theme 2 is appropriate?

Q8 Please tell us if you have any views about theme 2.

Q9 There are six objectives under theme 2. To what extent do you agree or disagree that the objectives under theme 2 are appropriate?

Q10 Please tell us if you have any views about the objectives under theme 2.

Q11 There are four strategic outcomes under theme 2. To what extent do you agree or disagree that the strategic outcomes under theme 2 are appropriate?

Q12 Please tell us if you have any views about the strategic outcomes under theme 2.

Q13 To what extent do you agree or disagree that theme 3 is appropriate?

Q14 Please tell us if you have any views about theme 3.

Q15 There are eleven objectives under theme 3. To what extent do you agree or disagree that the objectives under theme 3 are appropriate?

Q16 Please tell us if you have any views about the objectives under theme 3.

Q17 There are five strategic outcomes under theme 3. To what extent do you agree or disagree that the strategic outcomes under theme 3 are appropriate?

Q18 Please tell us if you have any views about the strategic outcomes under theme 3

Q19 Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the protected characteristics?

Q20 Do you think our proposals will have a positive or negative impact on any of these groups?

Q21 Please give comments explaining your answers to the two impact questions above. Please describe the individuals or groups concerned and the impact you think our proposals would have.

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