General Pharmaceutical Council

Consultation on guidance for pharmacist prescribers: analysis report

Contents

Executive summary

Background

Between March and June 2019, we asked for views on draft guidance to support pharmacist prescribers in meeting our standards for pharmacy professionals. Given the increase in the number of pharmacist prescribers, and other influencing drivers (for example new technologies being used for prescribing (remote and online)), we believe it is necessary to issue guidance that enables pharmacist prescribers to provide safe and effective care when prescribing.

The guidance sets out the key areas pharmacist prescribers should consider when prescribing to ensure safe and effective care. More specifically, we sought views on:

- the key areas for safe and effective prescribing
- the circumstances to consider when it is appropriate to prescribe safely
- prescribing and supplying
- safeguards for remote prescribing of certain categories of medicines, and
- the impact this guidance may have on various stakeholder groups

We delivered the consultation through an online survey and held both a stakeholder roundtable event and three patient focus groups in England, Scotland and Wales.

There were **284** responses to the online survey: **37** responses were received from organisations **247** from individuals (**154** from prescribers). There were also **six** additional responses which did not follow the structure of the survey: **two** from individuals and **four** from organisations. There were **nine** stakeholders who attended our roundtable event and **58** individuals attended our patient focus groups.

Key issues raised in responses

General views

The consultation sought views on our guidance, specifically the key areas, factors and circumstances pharmacist prescribers should consider when prescribing safely and effectively. Overall, respondents were supportive of our proposals and were encouraged that guidance would be available in what was an emerging and developing issue in pharmacy practice. Some respondents took the opportunity to reflect on the widening roles and responsibilities of pharmacist prescribers in healthcare more generally and felt that the guidance would prove valuable in better understanding what was expected of them. In contrast, there were some concerns that our proposals on requirements to access and share patient records could undermine pharmacist prescribers and their ability to use their professional judgement. Many respondents found the guidance to be too focused on community pharmacy and queried how the guidance would apply to pharmacist prescribers working in other settings such as multi-disciplinary teams, hospitals and prisons. Some respondents also drew attention to our proposals on remote prescribing throughout. Whilst some respondents were against remote prescribing as a matter of principle, others felt that it should fall outside of the remit of pharmacist independent prescribers altogether. Respondents also made many suggestions on how our proposals could be strengthened and where further clarity was required. A small minority were also of the opinion that the guidance was unnecessary given the overlap with existing guidance from the General Medical Council (GMC) and the Royal Pharmaceutical Society (RPS), for example.

Views on the key areas for safe and effective prescribing

A large majority of respondents felt that the guidance identified all the necessary areas for ensuring safe and effective care. The areas that drew a favourable response included the importance of raising concerns and ensuring that pharmacist prescribers keep up to date with their level of competence. However, some felt that there was on overlap with the existing guidance in place from other organisations. Despite agreeing with many of the key areas, some respondents also called for more clarity in specific areas such as prescribing and supplying and remote prescribing. Other respondents drew attention to potential new areas which the guidance had not already considered or put forward their suggestions on how the existing areas could be improved or expanded.

Views on the circumstances to consider when it is appropriate to prescribe safely

A large majority of respondents agreed with the circumstances set out in the guidance that describe when a pharmacist prescriber must decide whether they can prescribe safely for a person. Many respondents also drew attention to other circumstances that were not already covered in the guidance. These include where the patient is vulnerable or lacks the capacity to make an informed decision about their level of care, where medication has been initiated by another party, and where a person is from outside the UK. The difficulties of sharing information and accessing medical records in non-community pharmacy settings was also a frequent theme raised throughout.

Views on prescribing and supplying

Our proposals on the circumstances where it may be necessary to prescribe and supply drew a varied response. Whilst the majority of respondents agreed that the initial prescribing should be kept separate from the supply of medicines prescribed, others identified a number of additional exceptional circumstances that could also be covered. These include in circumstances where there is an emergency, when there is no other prescriber available such as in hospital settings and for certain types of conditions e.g. minor ailments, travel vaccinations, etc.

Views on the safeguards for remote prescribing of certain categories of medicines

A slightly higher proportion of all respondents did not think there were any other safeguards that should be put in place to make sure certain medicines are prescribed safely and remotely, compared to those that thought there were. Some respondents also described other additional safeguards that the guidance did not already mention. These include when the prescribing involved drugs that were open to abuse or misuse such as opioids, the frequency in which they were prescribed and the quantity. Other safeguards that were raised include the requirements when prescribing remotely and when liaising with the regular prescriber or GP. Many respondents also emphasised the importance of having access to robust medical records when deciding if it was appropriate to prescribe remotely. Some respondents commented how technology-led consultations could work safely in practice, such as videoconferencing and video calling.

Impact the proposals may have on various stakeholder groups

A large majority of respondents thought that the proposals would have either a positive, or both a positive and a negative impact on patients and the public, pharmacist prescribers, other pharmacy professionals and employers or pharmacy owners. Many respondents focused on the patient safety angle and felt that the guidance would help to raise the standards of pharmacist prescribers more widely, to the benefit of both patients and the public. In contrast, others thought that the guidance was too restrictive and would make it more difficult for patients to access the medicines they require. The

majority of respondents did not think our proposals would discriminate or unintentionally disadvantage any individuals or groups sharing any of the particular protected characteristics in the Equality Act 2010. However, a few respondents believed that there was the potential for the elderly or disabled to be disadvantaged if medicines were not prescribed in a timely manner.

The consultation: what we did

1. Policy background

1.1. Over the past three years we have carried out extensive research to better understand the issues pharmacist prescribers face when carrying out their prescribing role. This included looking at information received through our prescribers' survey (2016), the enquiries we received through the education and standards teams and our inspectors, fitness to practise cases, our **discussion paper** on *making sure patients and the public obtain medicines and other pharmacy services safely online* (June 2018), recent reports and consultations and guidance produced by other regulators and professional bodies.

1.2. Following on from this, we have developed guidance for pharmacist prescribers to help ensure they provide safe and effective care to patients and the public and to help them understand their obligations as a prescriber and the importance of prescribing safely. The guidance applies to pharmacist prescribers working within the NHS or privately – including primary care and secondary care – and in healthcare roles within the armed forces and prisons. It supports the standards for pharmacy professionals and aligns with our regulatory aims as set out in our strategic plan 2017-20.

1.3. Our **standards for pharmacy professionals** apply to all pharmacy professionals in Great Britain, including pharmacist prescribers. Given the increase in the number of pharmacist prescribers and the development of remote and online prescribing, we believe it is necessary to issue guidance to help make sure pharmacist prescribers are meeting our standards.

1.4. Moreover, our **Strategic plan 2017-20** sets out our aim to use our regulatory powers to support and improve the delivery of safe, effective care and to uphold trust in pharmacy. One of the ways we do this is by making sure that pharmacist prescribers have the necessary knowledge and skills.

Analysis of consultation responses and engagement activities: what we heard

In this section of the report, the tables show the level of agreement/disagreement of survey respondents to our proposed changes, or the aspects respondents felt we should modify. 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.

2. Key areas for safe and effective prescribing

Table 1: Views on the key areas for safe and effective prescribing

Q1. Have we identified all the necessary areas for ensuring safe and effective care is provided?	N and % of individuals	N and % of organisations	Total N and % of respondents
Yes	188 (76%)	27 (73%)	**215 (76%)**
No	41 (17%)	9 (24%)	**50 (18%)**
Don't know	18 (7%)	1 (3%)	**19 (7%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

Table 2: Breakdown of views on the key areas for safe and effective prescribing

Q2. For each of the nine areas, do you agree or disagree with the guidance we have proposed?	N and % of individuals who agreed	N and % of organisations who agreed	Total N and % of respondents who agreed
Taking responsibility for prescribing safely	219 (89%)	24 (65%)	**243 (86%)**
Keeping up to date and prescribing within your level of competence	224 (91%)	29 (78%)	**253 (89%)**
Working in partnership with other healthcare professionals and people seeking care	225 (91%)	27 (73%)	**252 (89%)**
Prescribing in certain circumstances	217 (88%)	25 (68%)	**242 (85%)**
Prescribing non-surgical cosmetic medicinal products	156 (63%)	27 (73%)	**183 (64%)**
Remote prescribing	179 (72%)	29 (78%)	**208 (73%)**
Safeguards for the remote prescribing of certain medicines	184 (74%)	29 (78%)	**213 (75%)**
Raising concerns	232 (94%)	32 (86%)	**264 (93%)**

Q2. For each of the nine areas, do you agree or disagree with the guidance we have proposed?	N and % of individuals who agreed	N and % of organisations who agreed	Total N and % of respondents who agreed	
Information for pharmacy owners and employers of pharmacist prescribers	182 (74%)	28 (76%)	**210**	**4%)**

2.1 Summary of tables 1 and 2

2.1.1 Around three quarters of respondents (76%) agreed that the guidance identified all the necessary areas for ensuring safe and effective care (table 1). However, slightly more organisations (24%) felt that our guidance did not identify all the necessary areas compared to individuals (17%).

2.1.2 When looking at the key areas in more detail in table 2, raising concerns (93%), working in partnership with other healthcare professionals and people seeking care (89%), and keeping up to date and prescribing within a prescriber's level of competence (89%) were areas that received the most agreement.

2.1.3 The area that respondents were least likely to agree with were the provisions around prescribing non-surgical cosmetic medicinal products (63%). However, more respondents did not know (25%) rather than disagreed (11%) on whether this was an appropriate area identified in the guidance.

2.1.4 The area that showed the widest disparity amongst individuals and organisations was in relation to taking responsibility for prescribing safely. A larger proportion of organisations (32%) disagreed with this proposal compared to individuals (10%).

2.1.5 Around 60% of respondents left explanatory comments to this question. The following is an analysis of the themes found in these comments and from the wider engagement events.

2.2 Summary of themes

2.2.1 Responses to this question covered a wide range of themes, many of which related to subsequent questions and are therefore discussed later in this report. This includes the provisions around accessing medical records (see section 6.4), requiring consent to access records (see section 6.5), sharing information across different settings (see section 6.6) and concerns around remote prescribing (see section 8).

2.2.2 The most prevalent themes found in response to this question were:

- That the guidance was too focused on community pharmacy and does not reflect all settings
- Reference to existing guidance
- Risk of misuse or unethical practice
- Gaps in the guidance

2.3 General support of proposals

2.3.1 Many responses to this question felt that the key areas identified were comprehensive and reflective of the standards for pharmacy professionals and standards for registered pharmacies which would help to ensure safe and effective care.

2.3.2 A few respondents were encouraged that the guidance covered new and growing practices such as remote prescribing and prescribing non-surgical medicinal products. However, given the specialist nature of these areas, many were unable to determine if these were appropriately covered in the guidance due to a lack of familiarity or understanding of these specialist areas.

2.3.3 Some respondents largely agreed with our proposals but took the opportunity to highlight how specific areas could be further strengthened, for example, by providing examples or more context for each area that expands on the variables of the setting and scope.

2.4 Other settings

2.4.1 Despite agreeing with the proposals, many felt that the key areas could do more to explain or take into account the practical differences across different pharmacy settings.

2.4.2 Throughout the consultation, a large number of respondents felt that the guidance was too heavily focused on community pharmacy and could do more to account for the different procedures and processes in place across other settings, such as hospitals and prisons.

2.4.3 For those with experience in hospital settings it was suggested that the proposals did not reflect the reality of much day-to-day hospital practice, compared to community settings. This includes the different time pressures that pharmacist prescribers are under, the requirements for working as part of a multi-disciplinary team, the different levels of consent and the urgency for prescribing required for some patients.

2.4.4 Many respondents drew attention to the multi-disciplinary team-working aspect in place across hospital settings where pharmacist prescribers are often expected to prescribe as part of the ward round. In these circumstances, it was pointed out, a pharmacist prescriber would typically prescribe under the direct guidance of another prescriber, such as a consultant. Many respondents felt that the guidance failed to capture this aspect of the pharmacist prescriber's role.

2.4.5 In addition, respondents also indicated that in hospital settings it may not always be the sole responsibility of a pharmacist prescriber to prescribe, instead it was often a team responsibility. It was also pointed out that the levels of consent required in hospitals was different to that in community pharmacy settings. For example, those admitted to hospital were likely to have more serious debilitating conditions which can impact on the prescriber's ability to obtain consent easily.

2.4.6 Some respondents also felt that the requirement to ask for consent from the regular prescriber to access medical records in some settings was unnecessary (see section 6.6.1). This was on the basis that pharmacist prescribers who work in hospitals or GP clinics, would have the same access to the comprehensive medical records as the regular prescriber (e.g. the General Practitioner) would anyway.

2.4.7 A small number of respondents felt that the requirement for the patient to be referred by the pharmacist prescriber by their usual prescriber would prove problematic in emergency, intensive or urgent care, where time is of the essence.

2.4.8 In prison environments, it was noted by a few respondents that prescribing can be difficult as many of the detainees are not registered with GPs, do not have access to a regular prescriber in the first place, are often from overseas, and may not speak English. Applying the guidance in these settings would prove difficult, it was inferred.

2.5 Existing guidance already in place

2.5.1 A common theme that emerged was how our guidance would sit in relation to the existing resources already in place, including from the General Medical Council (GMC), Royal Pharmaceutical Society (RPS) and Healthcare Education England (HEE). Whilst many respondents were pleased that the GPhC made reference to existing guidance, others felt that more could be done to ensure a more consistent approach to how the guidance was applied in relation to the other resources.

2.5.2 Reference to the GMC's guidance was made throughout. A few respondents indicated that our guidance should mirror the GMC's particularly where it states that the patient's usual prescriber should be informed when prescriptions are written for family members.

2.5.3 Areas where we were perceived to be inconsistent were flagged by a few respondents. For example, it was suggested that our guidance on taking responsibility for prescribing safely did not fully reflect current guidance and thinking on shared decision making and the legal requirement for supporting patients to understand their treatment options.

2.5.4 A very small minority indicated that the key areas identified in the GPhC guidance were unnecessary, given the existing guidance already in place. However, a larger proportion felt that guidance in this area provided an opportunity to ensure that we were consistent in the collective message that we were sending.

2.5.5 Attendees at the roundtable event and patient focus groups called for a more integrated approach to prescribing across the different health professions. However, a small minority were concerned about the lines being blurred between doctors and pharmacist prescribers, which could be confusing for the public.

2.6 Risk of misuse or unethical practice

2.6.1 Many respondents felt that certain aspects of the guidance were open to abuse or could be at risk of being misused. For example, some respondents in both the online survey and the engagement events were uncomfortable with the idea of their confidential medical records being shared more freely across different settings. They felt that it increased the potential for people to use their records maliciously.

2.6.2 A large number of respondents felt that the proposals on remote prescribing was the area that was most vulnerable to being exploited. Many indicated that it would be easier for people to circumnavigate the proposals by illegally advertising prescription medicines if this form of prescribing became more common.

2.6.3 Some respondents were concerned that employers could use pharmacist prescribers to drive targets for financial gain and at the expense of supporting and training their employees. They also thought that the guidance could be strengthened to differentiate between appropriate

incentives such as guidelines and formularies and inappropriate incentives such as sponsorships or financial rewards.

2.6.4 Some respondents welcomed the guidance which states that remote prescribing would not be appropriate in cosmetic medicine. However, they warned that in providing room to exercise clinical judgement, the potential for financial exploitation, in this area, could increase. They recommended that the criteria be amended to reflect this, or that it clarifies how pharmacist prescribers can manage incentives or targets in an ethical way.

2.6.5 A few other respondents felt that the proposals may increase the number of medical or dispensing errors if medical records, that were relied on by pharmacist prescribers, were inaccurate to begin with. For example, some respondents believed that the NHS Summary Care Records were sometimes out-of-date (see section 6.4).

2.7 Other gaps

2.7.1 Some respondents at both the patient focus groups and in the online survey were uncomfortable with the idea of allowing pharmacist prescribers to prescribe for conditions other than minor ailments. Whilst agreeing that pharmacist prescribers should provide a responsive service based on the needs of their local community, some felt that the types of services on offer should be restricted to GPs who have more experience and time to deal with certain conditions.

2.7.2 Respondents put forward their suggestions on potential new areas not already identified or where key improvements could be made to the existing areas. A small number of respondents thought that:

- the guidance did not provide enough focus on the difficulties of diagnosing as a prescriber.
- the circumstances involving the initiation and continuation of medicine could be strengthened in the guidance. Some thought it may be more appropriate to ensure the continuation of a supply without having to contact the GP, for example upon discharge from hospital settings.
- the terminology was too vague which made it difficult to assess how the key areas would be applied in practice.
- ‘scope of competence’ could apply to non-prescribing aspects of the prescribing role such as having the necessary knowledge of IT systems in different settings such as hospitals or GP practices. A small number felt that this aspect needed clarification with more context.
- transcribing could be a new area or an addition to an existing area in the guidance.
- the key areas did not adequately cover the non-prescribing aspects of the prescribing role such as referrals, test requests and follow-up of care.
- more emphasis could be placed on the holistic care of the patient to reflect the widening role of the pharmacist prescriber.
- key areas in the guidance did not focus on shared decision-making and the involvement of patients in decisions around medicines optimisation, prescribing and de-prescribing.

- the guidance should make explicit reference to the duty of candour or the need to be open and honest with patients and those using the services of pharmacist prescribers when things go wrong.
- the current wording in the guidance did not reflect the GPhC's 2017 guidance on religion, personal values and beliefs. In particular, they felt that the guidance could do more to recognise the right of pharmacist prescribers to practice in line with their conscientiously held beliefs.

3. The circumstances to consider when it is appropriate to prescribe safely

Table 3: Views on the circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person

Q4. Do you agree or disagree that these are circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?	N and % of individuals	N and % of organisations	Total N and % of respondents
Agree	213 (86%)	29 (78%)	**242 (85%)**
Disagree	29 (12%)	6 (16%)	**35 (12%)**
Don't know	5 (2%)	2 (5%)	**7 (2%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

Table 4: Views on if there are any other circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person

Q5. Are there any other circumstances where a pharmacist prescriber must decide whether they can prescribe safely for a person?	N and % of individuals	N and % of organisations	Total N and % of respondents
Yes	116 (47%)	20 (54%)	**136 (48%)**
No	64 (26%)	13 (35%)	**77 (27%)**
Don't know	67 (27%)	4 (11%)	**71 (25%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

3.1 Summary of tables 3 and 4

3.1.1 Table 3 shows that a large majority (85%) of individuals and organisations agreed with the circumstances in the guidance that outline when a pharmacist prescriber must decide whether they can prescribe safely for a person.

3.1.2 Agreement was slightly higher among individuals (86%) compared to organisations (78%).

3.1.3 When asked if there were any other circumstances not already identified, table 4 shows that around half of all respondents felt that there were. A slightly higher proportion of organisations felt that there were other circumstances (54%) compared to individuals (47%), however, a larger proportion of individuals (27%) did not know if there were any other circumstances compared to organisations (11%).

3.1.4 Around 55% of respondents left explanatory comments. The following is an analysis of the themes found in these comments.

3.2 Summary of themes

3.2.1 Many of the responses to this question covered the themes identified in section 5 above and have therefore not been repeated here.

3.2.2 Respondents to this question raised a number of points on the circumstances identified in the guidance when it is safe to prescribe safely. They also put forward suggestions on any additional circumstances that had not already been considered.

3.2.3 The most common themes identified include those who lack the capacity to make a decision on their care, accessing, sharing and requiring consent to patient records, and the differences in place across pharmacy settings (see section 5.4).

3.3 Those who lack the capacity to make a decision on their care

3.3.1 The issue that occurred most frequently and where respondents felt that further direction was required in the guidance related to when people or patients lacked the capacity to make a decision on their care. A few respondents also drew attention to their own personal experiences where as a prescriber, they have had to make a difficult prescribing decision when a patient does not have the capacity to consent. Most of these real-life examples occurred in hospital settings, which some felt needed to be better reflected in the guidance (see section 5.3).

3.3.2 There was considerable discussion on what 'lack of capacity' entails. Where some used it as a broad term to describe those that are unable to make a decision on their care, others indicated that a lack of capacity could entail both physical and mental characteristics. For example, those that are intoxicated, unconscious, or are temporarily disabled due to injury or illness could all be seen to lack capacity.

3.3.3 Some respondents also highlighted the relationship between the pharmacist prescriber and the role of a third person who is legally responsible for making a decision about a patient's care. In particular, the welfare attorney and the Lasting Power of Attorney (LPA) were frequently mentioned as areas which the guidance needed to address. One respondent felt that in many circumstances the LPA would have more accurate information on the patient's medical history and that bypassing the LPA in the prescribing process would not be acceptable unless it was an emergency.

3.4 Accessing records

3.4.1 A common theme throughout this question and the wider consultation centred on our proposals around information sharing. In particular, the requirements around consent and when it is necessary to access and share information in order to prescribe safely were discussed at length.

3.4.2 Many respondents were encouraged that the guidance made it clear that in order to prescribe safely it was important that pharmacist prescribers had access to the person's medical records. However, the difficulties in accessing such records was flagged throughout the consultation responses.

3.4.3 Whilst many respondents agreed that it was highly desirable to access a patient's medical records, they also felt that this was very rarely achievable in practice, particularly across different settings. Moreover, the disconnect between community and hospital settings in the sharing of information was mentioned throughout.

3.4.4 Many felt that further work was required to address this to ensure that the guidance is applied as intended. For example, some believed that ideally, pharmacists in community settings should have routine access to the emergency care summary records and clinical portal when assessing whether or not it is safe and clinically appropriate for them to prescribe. However, currently this was not always the case.

3.4.5 On this, some respondents also criticised the summary care records (SCR) and felt they weren't an appropriate source of information to rely on in isolation. They also believed that the SCR were prone to being inaccurate, were not able to be updated by the pharmacist prescriber themselves and did not always contain robust information to make an appropriate decision on whether to prescribe safely. As a result, a few respondents thought that it was good practice for pharmacist prescribers to use two sources of information instead of just one in order to prescribe safely. For example, test/consultation results and hospital letters were cited as example of alternative sources of information pharmacist could use to make a decision on whether it is safe to prescribe.

3.5 Sharing information

3.5.1 Respondents also queried the type of medical information that should be shared across different settings. Some thought that it was important not to restrict the sharing of information to only that of medicines. Instead, they thought that information sharing should be a broad term that captures the relevant clinical information and up-to-date test results to help the pharmacist prescriber to decide if it is safer to prescribe or delay treatment.

3.5.2 A few respondents noted that it was not common practice for NHS records to be shared with practitioners in the private clinics. They queried how the guidance would address this.

3.5.3 Some respondents also felt that it was not always necessary for pharmacists to share information or communicate each prescribing episode. Instead they thought that it depended on the type of condition being treated and the patient's condition. Respondents also thought that pharmacists should be encouraged to use their professional judgement and due diligence to arrive at a professional and clinical decision to share information based on the individual's circumstances.

3.6 Asking for consent to access medical records

3.6.1 A number of respondents were concerned about the requirement for pharmacist prescribers to gain consent from the 'regular prescriber' in order to access patients' records. However, it came to light during the consultation period that this was an error in the **consultation document**. Many felt that the guidance should be amended to explain that pharmacist prescribers should seek consent from the patient rather than from the regular prescriber, as it was originally intended.

3.6.2 As this was not routine practice at present there were concerns that this proposal would have the biggest impact and could lead to significant upheaval. For example, some drew attention to the fact that not all patients have a regular prescriber in the first place or would want their regular prescriber to know every detail of their discussion with the pharmacist prescriber. Others felt that this proposal was an onerous step in the prescribing process especially if the patient had already provided consent in the first instance either directly or indirectly which was often the case in hospital settings.

3.6.3 A small number of respondents implied that our proposal had the potential to undermine the role of the pharmacist prescriber altogether. This was on the basis that it reinforces a subordinate position for pharmacist prescribers where they could be prevented from providing care for a patient based on the opinion of another healthcare professional. Some respondents also thought that pharmacist prescribers should be encouraged to use their professional judgement rather than having to liaise with the regular prescriber in every circumstance.

3.6.4 To address this, it was suggested that the term 'regular prescriber' should be clarified to ensure the guidance is applied in practice as it was intended.

3.6.5 A few respondents felt that it was possible for pharmacists to prescribe without requiring access to a patient's records on some occasions. Using malaria prophylaxis as an example, one respondent demonstrated that it would be enough to just question the patient for conditions of this nature. However, a larger number of respondents thought that it was possible for pharmacist prescribers to prescribe without access to medical records.

3.7 Other circumstances

3.7.1 Respondents briefly drew attention to other circumstances relating to the patient in which the pharmacist prescriber must decide whether they can prescribe safely. These include where the patient is:

- under the age of 18
- cannot speak English
- is a foreign national

3.7.2 Other more general circumstances were also identified, and include when/where the:

- pharmacist prescriber does not have the sufficient clinical assessment skills
- condition being treated is out of the prescriber's competency
- pharmacist prescriber may be required to discuss the benefits and harms of treatment options
- patient requires sensitivity relating to a person's personal choices, e.g. sexual orientation
- pharmacist prescriber and the patient have a close personal relationship
- there are insufficient facilities or equipment to carry out an evaluation of the patient's condition

3.8 Other comments and suggestions

3.8.1 For respondents who agreed with the circumstances outlined in the guidance, in explaining their reasons, they thought that it would help to ensure that pharmacist prescribers are prescribing safely and providing patient-centred care.

3.8.2 Despite the majority agreeing with the proposals, some respondents also made requests for clarification and put forward their suggestions on how to make the circumstances outlined in the guidance more effective.

3.8.3 For example, a handful of respondents took issue with the terminology, particularly relating to the 'circumstances' where a pharmacist prescriber must decide whether they can prescribe

safely. They felt that the guidance may benefit from making it clear that the circumstances listed are those that may be particularly prone to risks, as the phrase 'circumstances' in isolation is too wide-ranging. Respondents thought that the guidance could be made clearer to indicate that any single one of the circumstances would trigger a pharmacist prescriber to decide whether it is safe to prescribe.

3.8.4 A few respondents thought that whilst all the circumstances were covered in the guidance, it was unclear if the extent and scope of some of the more advanced prescribing roles had been fully considered. As a result, the circumstances may be more wide-ranging than first thought and may need to be revised in the future.

3.8.5 Some respondents who also agreed with the circumstances in principle, warned that there may be an unintended consequence of reducing the autonomy of pharmacist prescribers on occasions where they would have to ask for consent from the person's regular prescriber to access their medical records.

3.8.6 An organisational response felt that the circumstances outlined in the guidance were appropriate apart from in situations 'when the person has not been referred to the pharmacist prescriber by their own prescriber'. In explaining their reasons, they outlined that there may be occasions when a person may be referred to a pharmacist prescriber by another member of the healthcare team such as a community matron or practice nurse. In these circumstances, it was noted that it may still be appropriate to prescribe as long as the pharmacist prescriber has access to the relevant health records and are competent to prescribe.

4. Prescribing and supplying

Table 5: Circumstances where a pharmacist prescriber should be able to prescribe and supply

Q7. Are there any other circumstances where you think a pharmacist prescriber should be able to prescribe and supply?	N and % of individuals	N and % of organisations	Total N and % of respondents
Yes	92 (37%)	15 (41%)	**107 (38%)**
No	101 (41%)	20 (54%)	**121 (43%)**
Don't know	54 (22%)	2 (5%)	**56 (20%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

4.1 Summary of table 5

4.1.1 Table 5 shows that there was a mixed response on whether there were any other circumstances where a pharmacist prescriber should be able to prescribe and supply safely. In total, 38% of all respondents thought that there were additional circumstances, only slightly less than those who agreed that the guidance had identified all the circumstances for prescribing and supply (43%).

4.1.2 Around a fifth of all respondents stated that they did not know if there were any other circumstances other than those outlined in the guidance.

4.1.3 Organisations and individuals were relatively consistent on their views to this question. Slightly more organisations (41%) felt that there were other circumstances, compared to individuals (37%). However, a much larger proportion of individuals (22%) did not know if there were any other circumstances compared to organisations (5%).

4.1.4 Around a third of respondents left explanatory comments to this question. The following is an analysis of the themes found in these comments.

4.2 Summary of themes

4.2.1 Responses to this question provided a description of some of the exceptional circumstances when it may be appropriate for pharmacist prescribers to prescribe and supply.

4.2.2 The most common circumstance put forward in the responses was in emergency or acute situations and when no other prescriber was available, such as in remote or isolated locations. Many respondents drew attention to how the circumstances, when it may be necessary to prescribe and supply, can vary between the different settings in which a pharmacist prescriber works. A large number of respondents also drew attention to items that are prescribed on a regular basis as an example of when it may be necessary to both prescribe and supply.

4.3 Emergency supply or acute situations

4.3.1 Many respondents felt that emergency, life threatening, or acute situations would constitute an exceptional circumstance where it may be necessary to prescribe and supply. There was some further discussion on what a genuine emergency supply situation would entail and the context in which emergency situations occur. For example, it was pointed out that an emergency situation in a hospital may differ to that in a community pharmacy.

4.3.2 An emergency supply, for many respondents, was appropriate when there was a genuine patient safety issue, such as a risk of overdose. Respondents also provided some other circumstances where it would be appropriate to prescribe and supply urgently, for example glucose gel or glucagon for hypoglycaemia, adrenaline for anaphylaxis, and salbutamol inhaler for an asthma attack.

4.3.3 Other examples of when an emergency situation could occur include:

- at festivals or large gatherings
- administering palliative care
- serious conditions that require urgent treatment, such as sepsis

4.3.4 A few respondents felt that the pharmacist prescribers should not be able to prescribe outside their scope of competence even in emergency or life-threatening situations. Instead, they indicated that pharmacist prescribers should balance their scope of competence against the duty of care and take time to evaluate the consequences of both.

4.4 Where no other prescriber is available

4.4.1 Many respondents also drew attention to circumstances where there are no other prescribers routinely available. These include at the point of discharge in hospital or secondary care settings or on occasions when there is only one pharmacist available in a small community pharmacy, for example.

4.4.2 Many respondents thought that prescribing and supply may also be appropriate for pharmacist prescribers working out of hours or on call, particularly in hospital settings. It was noted by some that in these circumstances there may be no other prescribers available to carry out final accuracy checks or a check for clinical appropriateness.

4.4.3 Some respondents also felt that it may be necessary to prescribe and supply in remote or rural locations where pharmacist prescribers are often alone and where no other checking process is practical or readily available. On this, respondents broadly felt that it would be to the detriment of patients and the wider community if pharmacist prescribers were not able to prescribe and supply in these circumstances. However, one respondent had a contrasting view and thought that the guidance could be open to abuse if pharmacist prescribers had licence to freely prescribe and supply in these circumstances.

4.5 Other settings

4.5.1 As with the other questions, many respondents drew attention to the processes and procedures in place across other pharmacy settings such as hospitals, where the types of situations that pharmacist prescribers experience can be more complex compared to those in community pharmacy settings.

4.5.2 A few respondents indicated that it is often necessary for pharmacist prescribers in hospital settings to prescribe and supply items to ensure the continuity of care and that it can be impractical and inefficient for a second prescriber to be involved in the supply process, particularly in emergency departments.

4.5.3 A small number of respondents also felt that it was very common in hospital practice for pharmacy technicians to supply medicines where the initial check was made by a pharmacist. Those that raised this issue felt that the guidance should cover this scenario.

4.6 Items prescribed on a regular basis

4.6.1 A large number of responses thought that there were specific items or medicines where it would be appropriate for pharmacist prescribers to both prescribe and supply. In explaining why, they felt that it was more efficient for both the patient and the pharmacy to ensure the flow of patient care is maintained, if some items were prescribed and supplied by the pharmacist.

4.6.2 A few respondents drew attention to the Minor Ailments Scheme where it was thought that pharmacist prescribers were already prescribing and supplying, to a lesser extent.

4.6.3 Other items that respondents put forward where it may be appropriate for pharmacist prescribers to prescribe and supply include:

- Influenza vaccine
- Non-surgical cosmetic products such as Botox or fillers
- Emergency contraception
- Travel vaccinations

4.7 Other issues

4.7.1 A few responses drew attention to the complexity of the supply process which can often entail a number of different steps carried out by a number of different people with different roles. They felt that the guidance needed to be clearer and unambiguous on which steps should be avoided. To address this, it was suggested that a risk-based process would be more appropriate to describe how prescribing and supplying should be managed.

4.7.2 Some respondents thought that our proposals should align with what is in place for similar roles across other healthcare professions. Reference was occasionally made to dispensing doctors who for some, had more freedom to carry out their professional judgement when deciding whether it was safe to prescribe and supply.

4.7.3 A few respondents drew attention to some of the differences in the pharmacy services under the NHS contract across Great Britain, particularly in Scotland.

4.7.4 A few respondents indicated that pharmacist prescribers would be required to make a professional judgement on whether it would be safe to prescribe and supply based on their scope of competency and their responsibility to provide a duty of care.

5. Safeguards for remote prescribing

Table 6: Views on the safeguards for remote prescribing

Q9. Are there any other safeguards that should be put in place to make sure certain medicines are prescribed safely remotely?	N and % of individuals	N and % of organisations	Total N and % of respondents
Yes	67 (27%)	21 (57%)	**88 (31%)**
No	96 (39%)	13 (35%)	**109 (38%)**
Don't know	84 (34%)	3 (8%)	**87 (31%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

5.1 Summary of table 6

5.1.1 As reflected in the figures in Table 6, responses to this question were mixed.

5.1.2 A slightly higher proportion of all respondents did not think that there were any other safeguards that should be put in place to make sure certain medicines are prescribed safely and remotely (38%), compared to those that thought there were (31%). A similar proportion of respondents did not know if there were any other safeguards that should be put in place (31%).

5.1.3 A much higher proportion of organisations (57%) thought that there were other safeguards compared to individuals (27%). However, proportionally more individuals (34%) stated that they did not know compared to organisations (8%).

5.1.4 Just over a quarter of respondents left explanatory comments in their response to this question. The following is an analysis of the themes found in these comments.

5.2 Summary of themes

5.2.1 Respondents spoke at length on some of the more general and practical concerns associated with remote prescribing. Whilst some voiced their opposition and felt that it was open to abuse, others thought that remote prescribing could prove successful depending on how it was implemented.

5.2.2 Many respondents also emphasised the importance of having access to robust medical records when deciding if it was appropriate to prescribe remotely. Respondents also drew attention to the additional safeguards that they felt should be considered as part of the requirements to prescribe remotely and described how the proposals could be strengthened.

5.3 Concerns regarding remote prescribing

5.3.1 Respondents to this question focused more generally on some of the risks associated with remote prescribing as a prescribing method. The most frequent reason given by respondents was the perception that it was an inferior way of prescribing compared to the more traditional face-to-face assessment, and therefore carried with it more inherent risks to patient safety.

5.3.2 Some respondents took an even stronger stance and explained that remote prescribing should not happen under any circumstances and instead should be discouraged in all healthcare

professions. A small number of respondents were also sceptical of the employer's role in remote prescribing and felt they were motivated by purely commercial reasons.

5.3.3 Some respondents gave their opinion on the circumstances on when remote prescribing was acceptable and when it was not. Whilst some were outright against remote prescribing as a concept, others felt that the guidance could expand more on the types of remote prescribing that are available to ensure that the guidance is more robust.

5.3.4 A few respondents raised concerns of how the guidance would work in practice. For example, it was suggested that the proposals would put more pressure on GPs to respond to requests within the timescale that online prescribing services would require.

5.3.5 A few respondents were concerned with the proposals around the remote prescribing of non-surgical cosmetic medicines. In particular, they did not believe that there were any circumstances in which the remote prescribing of non-surgical cosmetic medicines could ever be considered as being 'urgent'. It was suggested that the wording in the guidance should be amended to reflect this.

5.4 Medicines at risk of abuse

5.4.1 Some respondents thought that additional safeguards needed to be in place for certain medicines when prescribing remotely. These include medicines that are subject to abuse or misuse such as laxatives, opioids, gabapentin and pregabalin. Others drew attention to controlled drugs, prescription-only medicines and over-the-counter medicines where safeguards needed to be in place.

5.4.2 A few respondents felt that having a 48-hour delay between prescribing and issuing the prescription for drugs liable to abuse would allow for the relevant checks with the regular prescriber to be made before a supply can happen. One respondent thought that there needed to be a more robust way in determining if there is a genuine clinical need to prescribe medicines that can be open to abuse.

5.4.3 A few respondents took issue with some of the proposals outlined in the guidance. In particular, the proposal that 'medicines that require ongoing monitoring or management' are unsuitable to be prescribed or supplied remotely, was problematic for some. A few respondents thought that some chronic conditions that require ongoing management such as thiopurines for inflammatory bowel disease were suitable to be prescribed remotely. It was suggested that a case-by-case approach would work better in practice rather than how the guidance is currently worded.

5.5 Different types of remote prescribing

5.5.1 Acknowledging that remote prescribing was a growing practice, many respondents sought to explain how technology-led consultations could work safely in practice. Some highlighted how videoconferencing and video calling could help to ensure that the patient's needs are easily identified through visual representation such as facial expressions and body language. A few respondents felt that the guidance could do more to highlight the different types of remote prescribing that are available.

5.5.2 One respondent also felt that this form of remote prescribing could help to define treatment options and prompt the prescriber to assess the patient's needs more clearly rather than over a webpage, which is the case for other types of remote prescribing.

5.5.3 A handful of respondents felt that the guidance focused too heavily on the online aspect of remote prescribing and did not account for the different ways in which prescribing can be done remotely. Some drew attention to telephone consultations which were common in pharmacist led clinics, for example.

5.6 Access to full medical records

5.6.1 A relatively large number of respondents felt that it was important for pharmacist prescribers to have access to patients' full medical records before deciding whether it was safe to prescribe remotely. Equally, a few respondents also thought that the sharing of information about the prescription with other health professionals, such as the patient's GP should be more than 'proactive' as outlined in the guidance.

5.6.2 However, as noted in section 6.4, the reliability of medical records was an issue for some respondents who thought that it was common for the records to be out-of-date or not readily accessible across different settings. Therefore, many who shared this opinion felt that medical records on their own should not be a prerequisite for pharmacists to prescribe remotely.

5.6.3 A few respondents thought that having clear and unobstructed communication channels between the pharmacist prescriber and the patient's regular prescriber was more important when prescribing remotely rather than the traditional forms of prescribing. It was also suggested that if no regular prescriber was available then the pharmacist should not prescribe at all.

5.6.4 Some respondents felt that it was crucial for the pharmacist prescriber to check the summary care records when the prescribing involves high-risk medicines.

5.7 Other safeguards

5.7.1 Respondents to this question put forward their suggestions on where any additional safeguards were required for pharmacists to prescribe safely. Reference was frequently made to the measures put in place by the CQC with a few respondents calling for greater consistency between the regulators.

5.7.2 Some respondents felt that more stringent identification checks needed to be put in place when prescribing remotely. This would ensure that medicines are prescribed to the intended person and consequently would provide greater transparency in the prescribing process.

5.7.3 Other safeguards suggested by respondents include:

- having a second regulatory check
- having an initial face-to-face consultation with the regular prescriber before it is possible to prescribe remotely
- a mechanism to assess capacity when conducting a remote consultation
- clearer processes for monitoring requirements
- photographic evidence of previous medication taken
- ensuring that delivery staff are appropriately trained to check a patient's identity
- having a limit on the quantity of drugs supplied
- not prescribing remotely for children
- a separation of remote prescribing from supply to reduce conflict of interest

6. Impact of the proposals

6.1 Impact of the proposals on patients and the public

Table 7: Views on the impact that the proposals will have on patients and the public

Q11. What kind of impact do you think our proposals will have on patients and the public?	N and % of individuals	N and % of organisations	Total N and % of respondents
Positive impact	169 (68%)	20 (54%)	**189 (67%)**
Negative impact	8 (3%)	1 (3%)	**9 (3%)**
Both positive and negative impact	49 (20%)	12 (32%)	**61 (21%)**
No impact	15 (6%)	1 (3%)	**16 (6%)**
Don't know	6 (2%)	3 (8%)	**9 (3%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

6.1.1 As Table 7 shows, the majority of respondents (67%) thought that the proposals would have a positive impact on patients and the public, and 21% felt that they would have both a positive and negative impact on patients and the public.

6.1.2 Very few respondents thought that the proposals would solely have a negative impact on patients and the public (3%).

6.1.3 A higher proportion of individuals (68%) felt that our proposals would have a positive impact on patients and the public compared to organisations (54%) and more organisations (8%) did not know if the proposals would have an impact on patients and the public compared to individual respondents (2%).

6.2 Impact of the proposals on pharmacist prescribers

Table 8: Views on the impact that the proposals will have on pharmacist prescribers

Q12. What kind of impact do you think our proposals will have on pharmacist prescribers?	N and % of individuals	N and % of organisations	Total N and % of respondents
Positive impact	164 (66%)	20 (54%)	**184 (65%)**
Negative impact	12 (5%)	1 (3%)	**13 (5%)**
Both positive and negative impact	57 (23%)	12 (32%)	**69 (24%)**
No impact	8 (3%)	1 (3%)	**9 (3%)**
Don't know	6 (2%)	3 (8%)	**9 (3%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

6.2.1 Table 8 reveals that the majority of respondents felt that the proposals would have a positive impact (65%) on pharmacist prescribers.

6.2.2 Around a quarter of all respondents (24%) thought that the proposals would have both a positive and negative impact on pharmacist prescribers.

6.2.3 A slightly higher proportion of individuals (5%) thought that the proposals would have a negative impact on pharmacist prescribers compared to individuals (1%).

6.3 Impact of the proposals on pharmacy professionals

Table 9: Views on the impact that the proposals will have on pharmacy professionals

Q13. What kind of impact do you think our proposals will have on pharmacy professionals?	N and % of individuals	N and % of organisations	Total N and % of respondents
Positive impact	145 (59%)	17 (46%)	**162 (57%)**
Negative impact	13 (5%)	1 (3%)	**14 (5%)**
Both positive and negative impact	41 (17%)	8 (22%)	**49 (17%)**
No impact	25 (10%)	8 (22%)	**33 (12%)**
Don't know	23 (9%)	3 (8%)	**26 (9%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

6.3.1 As highlighted in Table 9, very few respondents (5%) thought that the proposals would have a negative impact on pharmacy professionals. Instead, the majority thought that the proposals would have either a positive impact (57%) or both a positive and negative impact (17%).

6.3.2 Around a fifth of all respondents thought that the proposals would have no impact (12%) or did not know (9%) what kind of impact the proposals will have on pharmacy professionals.

6.3.3 Proportionally more individuals (59%) thought that the impact on pharmacy professionals would be positive compared to organisations (46%).

6.3.4 Proportionally more organisations (22%) thought that there would be no impact on pharmacy professionals compared to individuals (10%).

6.4 Impact of the proposals on employers or pharmacy owners

Table 10: Views on the impact that the proposals will have on employers or pharmacy owners

Q14. What kind of impact do you think our proposals will have on employers or pharmacy owners?	N and % of individuals	N and % of organisations	Total N and % of respondents
Positive impact	130 (53%)	13 (35%)	**143 (50%)**
Negative impact	18 (7%)	2 (5%)	**20 (7%)**
Both positive and negative impact	51 (21%)	16 (43%)	**67 (24%)**
No impact	10 (4%)	1 (3%)	**11 (4%)**
Don't know	38 (15%)	5 (14%)	**43 (15%)**
Total N of responses	**247 (100%)**	**37 (100%)**	**284 (100%)**

6.4.1 Table 10 shows that, in comparison to the other groups highlighted previously, fewer respondents thought that the impact on employers or pharmacy owners would be as positive. However, half of all respondents still believed that the overall impact would be a positive one.

6.4.2 A much larger proportion of organisations (43%) thought the proposals would have both a positive and negative impact on employers or pharmacy owners compared to individuals (21%). However, more individuals (53%) thought that the overall impact would be positive compared to organisations (35%).

6.4.3 Half of all respondents left explanatory comments to this question. The following is an analysis of the themes found in these comments.

6.5 Summary of the impact that the proposals will have on patients and the public, pharmacist prescribers, pharmacy professionals, and employers or pharmacy owners

6.5.1 Views on the overall impact that the proposals would have on the four groups identified above were mixed. Whilst many outlined how the proposals would have a positive impact and increase public and patient safety and provide additional support for pharmacist prescribers, others thought that the guidance was too restrictive in parts or would add to the burden and workload of pharmacist prescribers and pharmacy owners.

6.6 Increased public and patient safety

6.6.1 A large number of respondents thought that public and patient safety would improve, once the guidance had been implemented.

6.6.2 Reasons why respondents shared this view were varied. Some felt that the proposals would raise the standards of the pharmacy profession more widely, and thus lead to a more skilled workforce. Others thought that providing more robust and clearer guidance for pharmacists to follow could help increase public and patient safety.

6.6.3 Despite acknowledging that the positive impact would outweigh the negative impact for patients and the public, others warned that the guidance may need to be revised. A few respondents reiterated their opposition to remote prescribing and thought that there were potential risks to patients and the public if this aspect was not strengthened.

6.7 Increased support for pharmacist prescribers

6.7.1 Many respondents welcomed the guidance as it recognised and supported the roles and responsibilities of the pharmacist prescriber more generally. Some respondents thought that the guidance would empower pharmacist prescribers so that they can prescribe more confidently.

6.7.2 A few respondents also suggested that new guidance in this area would promote the role of the pharmacist prescriber across healthcare which could improve morale and public confidence in the profession.

6.7.3 Some respondents held a more opposing view. For example, it was noted that the guidance may inhibit some pharmacist prescribers from taking an active role in repeat prescribing, medicines reconciliation and the discharge process.

6.7.4 Some respondents thought that the proposals could have a more wide-reaching impact than initially anticipated. For example, it was noted by a few respondents that there was the potential for the proposals to improve the pharmacy sector more generally if more pharmacists become prescribers in the future.

6.8 Guidance too restrictive

6.8.1 Many respondents thought that the guidance could create some unnecessary barriers in the prescribing process and that it was too restrictive for pharmacist prescribers to carry out their functions efficiently. In particular, the proposals around accessing and sharing medical records was a sticking point for many who felt that the proposals were too cumbersome.

6.8.2 There were some concerns that the proposals could have the potential to overcomplicate the duties of the pharmacist prescriber which could prove detrimental in dynamic settings such as community pharmacy.

6.8.3 A few respondents held slightly stronger views and felt that the proposals went too far. They believed that the tone of the guidance from the outset was negative and undermining to the role of the pharmacist prescriber and that more could be done to capture the views of the wider profession.

6.8.4 A small minority felt that the guidance could make it more difficult for patients to access the medicine they require. This was on the basis that pharmacist prescribers would become too risk averse to prescribe confidently.

6.8.5 Although the guidance was perceived by many respondents to be restrictive, some thought that this was likely to be more of a short-term issue rather than anything long-term. A few thought that once pharmacy owners, employers and pharmacists adjusted their practice accordingly, the guidance may prove less restrictive in the long-term once they become accustomed to the measures in place.

6.9 Increased burden and workload

6.9.1 Many respondents felt that the proposals in the guidance could increase the workload and the demands expected of pharmacist prescribers and the wider pharmacy team. A rise in the amount of admin and paperwork, and the time required to review internal processes to ensure they meet the requirements in the guidance, was a concern for some.

6.9.2 A few respondents indicated that the requirements to access medical records would have the biggest impact on the wider pharmacy team. There were concerns that it could detract from the pharmacist's role if there was a requirement to carry out more stringent checks when accessing and sharing medical records. Some also felt that this could have a knock-on effect on patient care if providing a service takes longer than expected.

6.9.3 Some respondents also felt that the proposals would increase the scrutiny of pharmacy owners and employers who are tasked with ensuring that guidance is implemented as it was intended. A few respondents thought that employers would need to take care to formally separate the prescriber and dispenser role in future as well as ensuring that there is adequate staffing in the pharmacy on account of the changes coming into force. This was on the basis that some retail community pharmacists would be enticed into a prescriber role to which owners would need to react.

6.9.4 Some respondents felt that the guidance did not align with what is in place for other health professions. There were concerns that the burden and workload of GPs and nurses would increase if pharmacist prescribers did not have the confidence to prescribe and supply.

6.10 Other issues

6.10.1 The following is a sample of some of the less frequent issues that were raised in response to this question:

- Some respondents did not think that it would be possible to assess the impact that the proposals would have until the guidance had been fully implemented.
- A handful of respondents felt that the guidance would have no impact, or a negative impact. Reasons for this included that the proposals would go unnoticed by the public whereas pharmacists and employers may find that it restricts their practice in some form.
- Some respondents also thought that employers may exploit or influence the prescribing habits of pharmacist prescribers once the guidance had been implemented. Others warned that employers or owners may seek to gain financially from the proposals.
- There was concern in some quarters that the guidance had not fully considered the role of pharmacist prescribers in hospital settings. Some respondents thought that proposals had the potential to alienate this group of prescribers which could be perceived as a negative impact.

7. Impact of the proposals on people sharing particular protected characteristics

Table 11: Views on our proposals having a negative impact on any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

Q16. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below[1]?	N and % of individuals	N and % of organisations	Total N and % of respondents
Age	19 (8%)	1 (3%)	**20 (7%)**
Disability	14 (6%)	0 (0%)	**14 (5%)**
Gender reassignment	11 (4%)	0 (0%)	**11 (4%)**
Marriage and civil partnership	8 (3%)	0 (0%)	**8 (3%)**
Pregnancy and maternity	10 (4%)	1 (3%)	**11 (4%)**
Race	8 (3%)	0 (0%)	**8 (3%)**
Religion or belief	10 (4%)	0 (0%)	**10 (4%)**
Sex	2 (<1%)	1 (3%)	**3 (1%)**
Sexual orientation	8 (3%)	0 (0%)	**8 (3%)**
None of the above	217 (88%)	36 (97%)	**253 (89%)**

7.1 Impact of the proposals

7.1.1 As Table 11 shows, an overwhelming majority of respondents (89%) did not think our proposals would discriminate or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010.

7.1.2 The most common protected characteristic that respondents thought would be negatively impacted by our proposals were individuals or groups with a disability (5%), followed by gender reassignment, pregnancy and maternity and religion or belief (all 4%).

7.1.3 Almost all organisations (97%) thought that the proposals would not adversely impact groups or individuals sharing the protected characteristics identified above. In comparison, 88% of individuals shared the same view.

Table 12: Views on our proposals having a positive impact on any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

[1] Respondents were asked to tick all that apply

Q17. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below[2]?	N and % of individuals	N and % of organisations	Total N and % of respondents
Age	43 (17%)	2 (5%)	**45 (16%)**
Disability	40 (16%)	2 (5%)	**42 (15%)**
Gender reassignment	29 (12%)	3 (8%)	**32 (11%)**
Marriage and civil partnership	27 (11%)	3 (8%)	**30 (11%)**
Pregnancy and maternity	32 (13%)	3 (8%)	**35 (12%)**
Race	26 (11%)	2 (5%)	**28 (10%)**
Religion or belief	26 (11%)	2 (5%)	**28 (10%)**
Sex	31 (13%)	3 (8%)	**34 (12%)**
Sexual orientation	27 (11%)	3 (8%)	**30 (11%)**
None of the above	199 (81%)	34 (92%)	**233 (82%)**

7.1.4 Table 12 shows that 82% of respondents did not think our proposals would benefit any individual or groups sharing any of the protected characteristics in the Equality Act 2010. Those who thought our proposals would benefit people sharing protected characteristics most commonly selected age (16%), disability (15%) and pregnancy and maternity (12%) and sex (12%).

7.1.5 Just over one fifth of respondents provided open-ended feedback on whether our proposed guidance for pharmacist prescribers would positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. The following is an analysis of the themes found in these comments.

7.2 Summary of the impact that the proposals will have on people sharing particular protected characteristics

7.2.1 In general, respondents to this question focused more on the positive impact that the proposals would have on the those sharing particular protected characteristics rather than the negative aspect. Despite this, the most common theme identified in the responses to this question was that the guidance was too restrictive. A large number of respondents also explained their reasons on why they felt that the guidance would have no impact in relation to protected characteristics.

7.3 General support

7.3.1 Many respondents thought that the proposals would have an overall positive impact on people sharing particular protected characteristics. In explaining their reasons, they felt that the proposals were fair and beneficial to everyone and could not envisage the proposals negatively impacting the groups identified in this question.

[2] Respondents were asked to tick all that apply

7.3.2 A few respondents indicated that having clear and robust guidance in this area would ensure that it would not negatively impact on people sharing particular protected characteristics.

7.4 Guidance too restrictive

7.4.1 Some of the respondents who provided feedback were concerned that the guidance was too stringent which could adversely impact on all individuals, including those sharing particular protected characteristics.

7.4.2 They explained that pharmacist prescribers may be more reluctant to prescribe to certain groups of individuals based on the recommendations outlined in the guidance. Those that were young or old, who were pregnant, who were breastfeeding and disabled were seen to be most at risk.

7.4.3 Some respondents felt that those who struggle with face-to-face interaction would be impacted the hardest if the proposals around remote prescribing were not implemented as intended.

7.4.4 A few respondents indicated that some individuals sharing protected characteristics may have a delay in their medicines, if pharmacist prescribers had to re-evaluate their competency once the guidance is implemented.

7.4.5 A handful of respondents were concerned that the proposals could impact on a patient's right to confidentiality. Some drew attention to those with discreet mental disabilities who may not want more than one healthcare professional accessing their medical records, at any given time.

7.4.6 The length of time it may take to access a patient's medical records was also an issue for some respondents. They felt that a delay in the time it takes to a prescribe a medicine could severely impact on those who are pregnant or disabled, for example.

7.5 No impact

7.5.1 A large number of respondents thought that the proposals would have no impact at all on the groups of people identified above. It was noted by many that the guidance would apply equally to all individuals or groups but that it would depend on how it was interpreted or applied in practice.

7.6 Other issues

7.6.1 The following is a sample of some of the less frequent issues raised in response to this question:

- It was noted by some, that the guidance may help to increase awareness of the role of pharmacist prescribers which could help elderly people take advantage of extra services.
- Some respondents thought that the proposals would be beneficial to everyone as it would increase the availability of services.
- A few respondents thought that the proposals would increase the safety, effectiveness and quality of patient care.
- An organisational response called for pharmacists to adopt a person-centred approach to ensure the guidance has a positive impact. They thought that pharmacist prescribers should recognise the diverse needs and identities of patients including the specific health needs of LGBT people.

Appendix 1: Summary of our proposals

The guidance for pharmacist prescribers reflects the themes of our standards for pharmacy professionals and our standards for registered pharmacies, to ensure patients receive safe and effective care. It includes information for pharmacy owners and employers of pharmacist prescribers and safeguards for remote prescribing of certain medicines. We have also included a section on non-surgical cosmetic medicines within our guidance. Specifically, we asked for views on the following themes.

1. The key areas for safe and effective prescribing

The guidance outlines nine key areas that relate to the provision of safe and effective prescribing. These are:

- taking responsibility for prescribing safely
- keeping up to date and prescribing within their level of competence
- working in partnership with people seeking care and other healthcare professionals
- prescribing in certain circumstances
- prescribing non-surgical cosmetic medicinal products
- remote prescribing
- safeguards for the remote prescribing of certain medicines
- raising concerns
- information for pharmacy owners and employers of pharmacist prescribers

2. The circumstances to consider when it is appropriate to prescribe safely

The guidance states the importance of having all the relevant medical information about a person and their medicines to ensure safe prescribing. This may be obtained by communicating with the person's regular prescriber or by having access to the person's medical records. We also provide information on what pharmacist prescribers **must do** in order to prescribe safely and the circumstances where they **must decide** whether they can prescribe safely.

3. Prescribing and supplying

The guidance states that pharmacist prescribers should usually keep the initial prescribing separate from the supply of the medicines prescribed, to protect the person's safety. It describes the exceptional circumstances when it may be necessary to prescribe and supply, and identifies certain circumstances when a pharmacist prescriber may prescribe and supply on a regular basis.

4. Safeguards for the remote prescribing of certain categories of medicines

The guidance describes the circumstances where it is appropriate to prescribe remotely, including online, for certain categories of medicines. It states that certain medicines are not suitable to be prescribed remotely unless further safeguards have been put in place to make sure they are clinically appropriate. We have proposed five safeguards for making sure certain categories of medicines are prescribed safely. These are:

- the prescriber has robust processes in place to check the identity of the person to ensure the medicines prescribed go to the right person
- the prescriber has asked the person for the contact details of their regular prescriber such as their GP and for their consent to contact them regarding the prescription
- the prescriber will proactively share all relevant information about their prescription with other health professionals involved in the care of the person (for example their GP)
- the prescriber has systems in place so that the pharmacy team can clearly document the prescriber's decision to issue a prescription if the person does not have a regular prescriber such as a GP or there is no consent to share information
- the prescriber is working within national prescribing guidelines for the UK and good practice guidance

5. The impact this guidance may have on various stakeholder groups

We are keen to understand the impact our proposals would have on the various stakeholders.

Appendix 2: About the consultation

Overview

The consultation was open for 12 weeks, beginning on 29 March 2019 and ending on 21 June 2019. To make sure 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 accepted postal and email responses
- we organised a series of stakeholder events aimed at pharmacy professionals, pharmacy service users, organisations and other interested parties
- we created a toolkit of materials for organisations to disseminate information about the consultation to their members, including a presentation, newsletter copy and social media guide.
- we promoted the consultation through a press release to the pharmacy trade media, via our social media and through our e-bulletin Regulate.

Survey

We received a total of **290** written responses to our consultation. **249** of these respondents identified themselves as individuals and **41** responded on behalf of an organisation.

Of these responses, **284** had responded to the consultation survey. The vast majority of these respondents completed the online version of the survey, with the remaining respondents submitting their response by email, using the structure of the consultation questionnaire.

Alongside these, we received **six** responses from individuals and organisations writing more generally about their views.

Stakeholder events

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 held **one** stakeholder event in London and discussed our proposals at **one** conference. These were attended by a mix of pharmacists, pharmacy technicians, people working in education and training, employers, pre-registration pharmacists, and representatives from professional bodies and trade bodies.
- We also met with **two** other stakeholders to discuss the proposals.
- We organised **three** patient focus groups, held in London, Glasgow and Cardiff.

A total of **67** individuals and representatives of organisations participated in these events.

Appendix 3: Our approach to analysis and reporting

Overview

Every response received during the consultation period including notes from stakeholder events and social media activity 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 themes 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.

If there were substantial differences between the views given in the consultation survey and those raised at stakeholder events, these differences are highlighted in the analysis.

Full details of the profile of respondents to the online survey is given in Appendix 4.

For transparency, Appendix 5 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.

The consultation questions are provided in Appendix 6.

Quantitative analysis

The survey contained a number of quantitative questions such as yes/no 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 5) 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 relevant questions in the survey has been followed in the 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’.

Cells with no data are marked with a dash.

Qualitative analysis

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

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 of the data.

Prevalence of views was identified through detailed coding of written responses and analysis of feedback from stakeholder events using the themes from the coding framework. The frequency with which views were expressed by respondents is indicated in this report with themes presented in order of prevalence. The use of terms also indicates the frequency of views, for example, the terms ‘many’/’a large number’ represent 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 in the narrative.

Appendix 4: Respondent profile: who we heard from

A series of background questions were included in the survey which sought information on the respondents, for example 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.

Category of respondents

Table 13: Responding as an individual or on behalf of an organisation

Are you responding: (*Base: all respondents*)	Total N	Total %
As an individual	247	87%
On behalf of an organisation	37	13%
Total N of responses	**284**	**100%**

Profile of individual respondents

Table 14: Countries

Where do you live? (*Base: all individuals*)	Total N	Total %
England	210	85%
Scotland	28	11%
Wales	7	3%
Other	2	<1%
Total N of responses	**247**	**100%**

Table 15: Individual respondent type

Are you responding as: (*Base: all individuals*)	Total N	Total %
a pharmacist	227	92%
a pharmacy technician	7	3%
a pre-registration trainee pharmacist	1	<1%
a pharmacy student	3	1%
a member of the public	5	2%
other	4	2%
Total N of responses	**247**	**100%**

Table 16: Prescribers

Are you qualified as: (*Base: pharmacists*)	Total N	Total %
an independent prescriber	110	48%
a supplementary prescriber	2	<1%
both an independent and supplementary prescriber	42	19%
none of the above	73	32%
Total N of responses	**227**	**100%**

Table 17: Types of prescribing services

What type of prescribing services do you provide? (*Base: prescribers*)	Total N	Total %
NHS	113	73%
Private	6	4%
Both NHS and private	17	11%
Not currently employed in a prescribing role	18	12%
Total N of responses	**154**	**100%**

Table 18: Prescribing remotely

Do you prescribe remotely (including online and over the telephone)? (*Base: currently employed in prescribing role*)	Total N	Total %
Yes	41	30%
No	95	70%
Total N of responses	**136**	**100%**

Table 19: Pharmacy owners

Are you a pharmacy owner/employer? (*Base: pharmacists and pharmacy technicians*)	Total N	Total %
Yes	19	8%
No	215	92%
Total N of responses	**234**	**100%**

Table 20: Main area of work

Please choose the option below which best describes the area you mainly work in? (*Base: individuals excluding pharmacy students and members of the public*)	Total N	Total %
Community pharmacy	51	21%
Hospital pharmacy	89	37%
Prison pharmacy	2	<1%
GP practice	47	20%
Primary care organisation	19	8%
Care home	1	<1%
Pharmaceutical industry	4	2%
Research, education or training	10	4%
Other	16	7%
Total N of responses	**239**	**100%**

Table 21: Size of community pharmacy

Which of the following best describes the community pharmacy you work in? (*Base: individuals working in community pharmacy*)	Total N	Total %
Independent pharmacy (1 pharmacy)	13	25%
Independent pharmacy chain (2-5 pharmacies)	7	14%
Small multiple pharmacy chain (6-25 pharmacies)	8	16%
Medium multiple pharmacy chain (26-100 pharmacies)	4	8%
Large multiple pharmacy chain (Over 100 pharmacies)	19	37%
Total N of responses	**51**	**100%**

Profile of organisational respondents

Table 22: Pharmacy and non-pharmacy organisations

Is your organisation: (*Base: all organisations*)	Total N	Total %
a pharmacy organisation	21	57%
a non-pharmacy organisation	16	43%
Total N of responses	**37**	**100%**

Table 23: 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	1	3%
Organisation representing pharmacy professionals or the pharmacy sector	11	30%
Independent pharmacy (1 pharmacy)	0	0%
Independent pharmacy chain (2-5 pharmacies)	0	0%
Small multiple pharmacy chain (6-25 pharmacies)	0	0%
Medium multiple pharmacy chain (26-100 pharmacies)	0	0%
Large multiple pharmacy chain (over 100 pharmacies)	2	5%
NHS organisation or group	11	30%
Research, education or training organisation	5	14%
Government department or organisation	0	0%
Regulatory body	2	5%
Other	5	14%
Total N of responses	**37**	**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. A separate equality impact assessment has been carried out and will be published alongside this analysis report.

Appendix 5: Organisations

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

Ayrshire and Arran Pharmacy Professional Committee

Bolton CCG

Boots UK

British Medical Association

Care Quality Commission (Medicines Optimisation Team)

Chief Pharmaceutical Officer's (CPhO) 2018/19 clinical fellows

Christian Medical Fellowship

Community Pharmacy Scotland

Community Pharmacy Wales

CPGUK

General Medical Council (GMC)

Greater Glasgow and Clyde Area Pharmaceutical Committee

Guild of Healthcare Pharmacists

Health Education England

Home Health UK Ltd

Joint Council of Cosmetic Practitioners (JCCP)

Leeds Teaching Hospitals NHS Trust

LGBT Foundation

Manchester University NHS Foundation Trust

National Pharmacy Association (NPA)

NHS Education for Scotland (Pharmacy)

NHS England

NHS Forth Valley

NHS Lothian

North East and Yorkshire and Humber Non-Medical Prescribing Networks

Northumbria Healthcare NHS Foundation Trust

Pharmaceutical Services Negotiating Committee

Pharmacists' Defence Association (PDA)

Pharmacy Forum NI

Professional Standards Authority (PSA)

Rowlands Pharmacy

Royal National Orthopaedic Hospital NHS Trust

Royal Pharmaceutical Society

Save Face

South West NMP Leads Network

Swansea University

Tees Esk and Wear Valleys NHSFT

The Company Chemists' Association Ltd

The University of Manchester

University of Bath

University of Bradford

Wandsworth CCG

Appendix 6: Consultation questions

This consultation is about draft guidance to support pharmacist prescribers in meeting our standards for pharmacy professionals, and to ensure they provide safe and effective care when prescribing. More specifically we are asking for views on:

- the key areas for safe and effective prescribing
- what pharmacist prescribers must do in order to prescribe safely
- prescribing and supplying
- safeguards when remotely prescribing certain categories of medicines, and
- the impact this guidance may have on various stakeholder groups

Key areas for safe and effective prescribing

In developing this guidance, we have identified nine key areas that relate to the provision of safe and effective prescribing.

1. Have we identified all the necessary areas for ensuring safe and effective care is provided?

- Yes
- No
- Don't know

2. For each of the nine key areas, do you agree or disagree with the guidance we have proposed?

- Taking responsibility for prescribing safely
- Keeping up to date and prescribing within your level of competence
- Working in partnership with other healthcare professionals and people seeking care
- Prescribing in certain circumstances
- Prescribing non-surgical cosmetic medicinal products
- Remote prescribing
- Safeguards for the remote prescribing of certain medicines
- Raising concerns
- Information for pharmacy owners and employers of pharmacist prescribers

3. Please explain your responses to the two questions above areas. (You will be asked questions later in the consultation about what pharmacist prescribers must do in order to prescribe safely, and to carry out both prescribing and supplying; and about the safeguards for remote prescribing)

Prescribing safely

In section 3.1 of our proposals we say that having all the relevant medical information about a person and their medicines is vital to ensure safe prescribing. This may be obtained by communicating with the person's regular prescriber or by having access to the person's medical records. We provide guidance on what pharmacist prescribers must do in order to prescribe safely, including:

- asking for consent from their regular prescriber to access a person's medical records
- giving the person receiving care clear information so they can make an informed decision, and
- discussing other available options when it is not appropriate to prescribe

We also describe circumstances where pharmacist prescribers must decide whether they can prescribe safely, such as when:

- they do not have access to the person's medical records
- the person refuses to give consent to contact their prescriber for more information
- the person has not been referred to the pharmacist prescriber by their own prescriber, or
- the person does not have a regular prescriber (such as a GP)

4. Do you agree or disagree that these are circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?

- Agree
- Disagree
- Don't know

5. Are there any other circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?

- Yes
- No
- Don't know

6. Please explain your responses to the two questions above and describe any additional circumstances that should be considered.

Prescribing and supplying

In section 4.2 of our proposals we say pharmacist prescribers should usually keep the initial prescribing separate from the supply of medicines prescribed, to protect the person's safety. We describe exceptional circumstances when it may be necessary to prescribe and supply, and have also identified certain circumstances when a pharmacist prescriber may prescribe and supply on a regular basis – for example, when administering travel vaccines.

7. Are there any other circumstances where you think a pharmacist prescriber should be able to prescribe and supply?

- Yes
- No
- Don't know

8. Please describe any additional circumstances that should be considered.

Safeguards for the remote prescribing of certain categories of medicines

In section 7 of our proposals we describe prescribing remotely, including online, for certain categories of medicines. We say that certain medicines are not suitable to be prescribed remotely unless further safeguards have been put in place to make sure they are clinically appropriate. In our recent discussion paper on our guidance for registered pharmacies providing pharmacy services at a distance, including on the internet, respondents agreed that before prescribing remotely, additional safeguards should be put in place to make sure the medicines are clinically appropriate for the person. We have proposed five safeguards for making sure certain categories of medicines are prescribed safely. These say that the prescriber must:

- have robust processes in place to check identities, to make sure the medicines prescribed go to the right person
- have asked the person for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription

- proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)
- have systems in place so that the pharmacy team can clearly document the prescriber's decision to issue a prescription if the person does not have a regular prescriber, such as a GP, or if there is no consent to share information
- work within national prescribing guidelines for the UK and good practice guidance

9. Are there any other safeguards that should be put in place to make sure certain medicines are prescribed safely remotely?

- Yes
- No
- Don't know

10. Please describe any additional safeguards you think there should be.

Impact of the proposals

We are keen to hear views about the impact of the draft guidance.

11. What kind of impact do you think our proposals will have on patients and the public?

- Positive impact
- Negative impact
- Both positive and negative impact
- No impact
- Don't know

12. What kind of impact do you think our proposals will have on pharmacist prescribers?

- Positive impact
- Negative impact
- Both positive and negative impact
- No impact
- Don't know

13. What kind of impact do you think our proposals will have on other pharmacy professionals?

- Positive impact
- Negative impact
- Both positive and negative impact
- No impact
- Don't know

15. Please give comments explaining your responses to questions 11 to 14.

Equality impact

We want to understand whether our proposals may discriminate against or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010.

16. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below? (Please tick all that apply)

- Age
- Disability

- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- None of the above

17. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below? (Please tick all that apply)

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- None of the above

18. Please describe the impact on each of the individuals or groups you have ticked in questions 16 and 17.