Council meeting
12 September 2019
13:30 to 16.00 approx.
Council Room 1, 25 Canada Square, London E14 5LQ

Public business

1. Attendance and introductory remarks
   Nigel Clarke

2. Declarations of interest
   All

3. Minutes of last meeting
   Public session on 11 July 2019
   Nigel Clarke

4. Actions and matters arising
   Nigel Clarke

5. Workshop summary – 11 July 2019
   For noting
   Nigel Clarke

6. Performance monitoring report and annual plan progress report
   For noting
   Duncan Rudkin

7. Vision 2030 summary
   For approval
   Claire Bryce-Smith

8. Initial education and training of pharmacists – consultation report
   For noting
   Mark Voce

   For noting
   Mark Voce

10. Registration assessment and Board of Assessors’ report – June 2019
    For noting
    Professor Andrew Husband and Damian Day

11. Regulation of investigatory powers – an update
    For noting
    Laura McClintock

12. Audit and Risk Committee minutes 17 July 2019 (unconfirmed)
    Public session - for noting
    Digby Emson

13. Any other public business
    Nigel Clarke
Confidential business

14. Declarations of interest  
   Confidential items
   All

15. Minutes of last meeting  
   Confidential session on 11 July 2019
   Nigel Clarke

16. Confidential actions and matters arising  
   Nigel Clarke

17. Audit and Risk Committee minutes 17 July 2019 (unconfirmed)  
   Confidential session - for noting
   19.09.C.08
   Digby Emson

18. Any other confidential business  
   Nigel Clarke

Date of next meeting

Thursday, 10 October 2019
Minutes of the Council meeting held on Thursday 11 July 2019 at 25 Canada Square, London at 13:30

TO BE CONFIRMED 12 September 2019

Minutes of the public session

Present

Nigel Clarke (Chair)      Alan Kershaw
Neil Buckley            Elizabeth Mailey
Digby Emson            Rima Makarem
Mark Hammond            Evelyn McPhail
Penny Hopkins            Arun Midha
Ann Jacklin            Aamer Safdar
Jo Kember              Jayne Salt

Apologies

None

In attendance

Duncan Rudkin (Chief Executive and Registrar)
Carole Auchterlonie (Director of Fitness to Practise)
Laura McClintock (Chief of Staff)
Francesca Okosi (Director of People)
Mark Voce (Director of Education and Standards)
Jonathan Bennetts (Associate Director of Finance and Procurement)
Damian Day (Head of Education)
Janet Collins (Governance Manager)
32. Attendance and introductory remarks

32.1 The Chair welcomed all present to the meeting.

33. Declarations of interest

33.1 Council agreed that members would make any declarations of interest before each item.

34. Minutes of the last meeting

34.1 There was a minor addition to the draft minutes which had been circulated. Paragraph 25.13 had the following sentence added: “There was a question about the quoted redundancy figures for 2018 and 2019, the background to them and the redundancy policy that was in operation. A report would be provided to the next meeting of the Renumeration Committee”.

34.2 With that addition, the minutes of the public session held on 13 June 2019 were confirmed as a fair and accurate record and signed by the Chair.

35. Actions and matters arising

35.1 Action 25.5 – the data analysis would be provided as part of the September Performance Management Report.

35.2 Action 25.8 – the evaluation of revised threshold criteria was underway.

35.3 Action 30.3 – regular updates on cyber security had been added to the Audit and Risk Committee agenda and the committee would provide an annual report to Council.

35.4 There were no matters arising.

36. Workshop summary – 13 June 2019

36.1 Council noted the discussions from the June workshop.

37. Initial education and training (IET) standards for pharmacists

37.1 Mark Voce (MV) introduced 19.07.C.01, which updated the Council on the emerging findings from the consultation on IET standards for pharmacists; the main decisions which needed to be made; and the approach to finalising the standards. The consultation had
received over 600 responses and the full analysis would be reported to Council in September.

37.2 There was considerable discussion around the emerging findings, following the themes highlighted in the paper namely: learning outcomes; integration; selection and admission and equality, diversity and fairness. Members made relevant declarations of interest before speaking in the discussion.

Learning outcomes

37.3 Discussions during the consultation period had suggested that initial training should provide a student pharmacist with the knowledge and skills needed to begin training as an independent prescriber, but that a period of experience was required before that person was ready to qualify to practise as an independent prescriber. However, as other healthcare professionals could prescribe on qualification, albeit under supervision, some members felt this was an issue which required further discussion before a final decision was taken.

37.5 The consultation events had heard from providers running training in prescribing who stressed the importance of diagnostic skills and experience of dealing with people which new graduates needed time to develop. There had, however, been some suggestion that a level of ability similar to supplementary prescribing, but not necessarily a formal annotation as such, would be appropriate.

37.6 It was noted that newly-qualified pharmacists had sufficient diagnostic and patient-management skills to recommend and sell appropriate medicines to patients from their first day in practice. With the rapid pace of change and development in the profession, some members were of the view that it would be disappointing if pharmacists graduating in the next five to ten years were not equipped to prescribe. However, it was also noted that the nature and degree of risk around independent prescribing by newly-registered pharmacists would vary according to the practice context and the local clinical and organisational governance and risk management structures.

37.8 One possibility could be to explore the feasibility of enabling a mixed economy of pharmacy degrees which incorporated the independent prescribing annotation and others which did not.

Integration

37.9 The consultation had shown broad support for the principle of greater integration of study and practical experience, although there was concern among respondents about the practical questions of delivery and funding. The willingness or otherwise of institutions to move forward with more integrated training would be heavily influenced by the availability of funding.
37.10 Planning was difficult, partly because pharmacy was moving so fast and it was difficult for IET to keep up with the developments. The ability of different training institutions to provide suitable placements for integrated training was another issue.

37.11 In response to a question, it was noted that proposals for the future of the pre-registration examination would form the second stage of the work. There was agreement that whatever emerged would need to be very clear with regard to the responsibility for signing pharmacists off as being ready for practice.

Selection and admissions

37.12 The paper noted that there had been broad support for proposals to require universities to assess the professional skills and attributes of prospective students. While the principle was supported, members commented that the phrasing should be amended as potential students could not be expected to already possess ‘professional skills’ at the point of selection.

37.13 There were mixed views among respondents about whether the GPhC should be more prescriptive in setting admission standards and it was likely to be a challenging area in which to reach agreement. The position on unconditional offers should be sense-checked with the universities.

37.14 Selection through the clearing process had also been considered and it was recommended that universities needed a values-based approach for admissions through this route, although there were practical issues to be thought through.

Equality, diversity and inclusion

37.15 Members noted the particular importance of equality, diversity and inclusion in selection and admissions processes.

General points

37.16 Members noted the ongoing work around post-registration foundation training and highlighted the importance of the GPhC being fully involved in the development of this work and the need to take account of it in finalising initial education and training standards.

37.17 The Council noted the proposed approach to finalising and implementing the standards with an emphasis on engaging further with relevant stakeholders on the practical and funding issues arising from integration. Council also noted the intention to make progress more quickly in relation to selection and admissions and equality, diversity and inclusion as these were not dependent on integration.
38. Revising the criteria for initial registration as a pharmacy technician

38.1 MV introduced 19.07.C.02, which proposed revisions to the criteria for initial registration as a pharmacy technician to reflect the introduction of integrated, or linked, knowledge and competence-based courses. These would take effect from 1 September 2019.

38.2 The 2017 IET standards emphasised the importance of integrated training and, as integrated or linked courses were now being put forward for accreditation, the criteria for registration needed to be updated to reflect this instead of referring to separate knowledge and competency qualifications. The proposed changes were highlighted in the document.

38.3 Trainees on existing accredited/recognised courses and qualifications would be able to continue on these as part of a transition to the new approach.

38.4 The Council agreed the revised criteria for initial registration as a pharmacy technician in Great Britain.

Penny Hopkins left the meeting.

39. Council appointments for 2020

39.1 Laura McClintock (LM) presented 19.07.C.03 which was a follow-up to the paper considered in May and which set out further recommendations around the process for filling vacancies on Council which would arise in March 2020. The paper included a progress report, updated selection criteria and competencies and a new Diversity Action Plan. It also set out a process for filling two vacancies through re-appointments.

39.2 LM thanked members for completing the self-assessment exercise which had helped in the development of the desirable criteria. No major skill gaps had been identified but there were some areas where experience could be strengthened. The essential criteria remained the same, but the wording had been simplified and more examples provided of ways in which an applicant could demonstrate meeting them. The proposed revisions also took account of feedback gathered through last year’s process, as well as relevant learnings in the external context relevant to our own work.

39.3 Council welcomed the developments, particularly the Diversity Action Plan. Some suggestions for further minor changes were made and accepted.

39.4 The Council:

i) noted the progress update on the recruitment of Council members through an open competition process;

ii) approved the updated selection criteria and competencies; and

iii) note the Diversity Action Plan designed to support the process of recommending appointments in 2020.
Jayne Salt and Elizabeth Mailey, both of whom were eligible for re-appointment, left the meeting for the following discussion.

39.5 The Council agreed the process for filling the remaining vacancies through re-appointments.

Jayne Salt and Elizabeth Mailey re-joined the meeting.

40. Any other public business

Guidance on ethical investment

40.1 Following a discussion in their workshop earlier in the day, the Chair read out the proposed guidance on ethical investment which would be used in the procurement process of an investment manager:

“The GPhC promotes safe and effective healthcare to the public and advocates good health. The GPhC has adopted an ethical investment policy to ensure that its investments do not conflict with its aims.

The GPhC will avoid any conflict of interest and will not allow direct investment into any company which owns pharmacies which it has regulatory responsibility for or the pharmaceutical industry.

The GPhC will also exclude direct investment in activities or products that are considered to be materially inconsistent with our organisations aims and will specifically exclude investment in companies whose principle purpose involves tobacco, alcohol and armaments.

The GPhC recognises some fund managers invest through a third party or pooled fund where we cannot directly influence the selection of individual investments. In these circumstances we require the fund managers to ensure that the proportion of excluded investments in the pooled fund is less than 10%. Companies which owns pharmacies which the GPhC has regulatory responsibility will still be excluded via indirect investment.

The GPhC will only invest through fund managers who are skilled in generating good investment returns and committed to and skilled at delivering our ethical requirements.”

40.2 The Council agreed the proposed wording

Evelyn McPhail left the meeting

UK and devolved governments’ consultation on regulation reform

40.3 Duncan Rudkin updated the Council on the public response to the consultation, which had been published on 9 July 2019. He welcomed the commitment to reforming Fitness
to Practise legislation and noted that, while there was still debate to be had about the number of regulators in the future, there were no current plans for merger or abolition.

Development of the 10-year vision

40.4 Claire Bryce-Smith would send a note round to Council members updating them on the stakeholder engagement which was taking place on the 10-year vision.

ACTION: CB-S

40.5 There being no further public business, the meeting closed at 15.30.

Date of the next meeting:
Thursday 12 September 2019
## Council actions log

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Ref.</th>
<th>Action</th>
<th>Owner</th>
<th>Due</th>
<th>Status</th>
<th>Comments/update</th>
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<tbody>
<tr>
<td>June 2019</td>
<td>25.5</td>
<td>Data analysis on voluntary removals to be shared with Council when more developed</td>
<td>MV</td>
<td>September</td>
<td>Complete</td>
<td>Included in the September PMR</td>
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<tr>
<td>June 2019</td>
<td>25.8</td>
<td>Evaluation of revised threshold criteria to be shared with Council</td>
<td>CA</td>
<td>Tbc</td>
<td>Open</td>
<td>Date to be confirmed as evaluation is underway</td>
</tr>
<tr>
<td>July 2019</td>
<td>40.4</td>
<td>Update members on stakeholder engagement on the 10-year vision</td>
<td>CB-S</td>
<td>September</td>
<td>Complete</td>
<td>See Item 7 on September agenda</td>
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</tbody>
</table>
Council workshop summary

Meeting paper for Council on 12 September 2019

Public business

Purpose

To provide an outline of the discussions at the Council workshop on 11 July 2019.

Recommendations

The Council is asked to note the discussions from the July 2019 workshop.

1. Introduction

1.1 The Council often holds a workshop session alongside its regular Council meetings. The workshops give Council members the opportunity to:

- interact with and gain insights from staff responsible for delivering regulatory functions and projects;
- receive information on projects during the development stages;
- provide guidance on the direction of travel for workstreams via feedback from group work or plenary discussion; and
- receive training and other updates.

1.2 The Council does not make decisions in the workshops. They are informal discussion sessions to assist the development of the Council's views. A summary of the workshop discussions is presented at the subsequent Council meeting, making the development of work streams more visible to stakeholders. Some confidential items may not be reported on in full.

2. Summary of the July workshop

Developing the Fitness to Practise strategy

2.1 Carole Auctherlonie (Director of Fitness to Practise) gave a presentation on the development of the Fitness to Practise (FtP) strategy. The presentation covered the drivers for change, including changes in pharmacy practice and the regulatory landscape, feedback from people who had been involved in the FtP process and increasing volumes of cases. CA explained the process to date, the engagement which had taken place, the key questions which were being discussed, the challenges involved and some potential solutions.
2.2 A number of ‘guiding principles’ had been set out for the work, which members discussed, and the next steps were explained. There would be a further discussion at the November workshop.

**Ethical investment strategy**

2.3 Jonathan Bennetts (Associate Director of Finance and Procurement) led a session on ethical investment, setting out the background to the work and the context in which the Council was seeking to increase the income gained from investments. The approach to investment was outlined, together with the governance framework within which it would be managed.

2.4 It was necessary for the Council to agree an ethical investment policy. Preliminary discussions about exclusions had been held at a previous workshop and this session developed the discussion further and explore the implications of some exclusions.

2.5 On the basis of the discussions, proposed guidance on ethical investments to be used in the procurement process for an investment manager would be put to the main meeting of Council for approval later in the day.

**Introducing the inspection website**

2.6 Claire Bryce-Smith (Director of Insight, Intelligence and Inspection) gave a brief introduction to the website which would house inspection reports when they were published. Members then split into three groups to take a closer look at the site, the search functions and the types of data that would be available.

**Science supporting the modern pharmacist and pharmaceutical scientist**

2.7 Professor Gino Martini, Chief Scientist at the Royal Pharmaceutical Society, joined the workshop to speak about the importance of pharmaceutical research, the role of pharmacists as medicines experts, the development of biologics, personalised medicines supply, pharmacogenetics and CAR-T, TCT and TIL therapies.

**Initial education and training standards – approach to finalising the standards**

2.8 Mark Voce (Director of Education and Standards) and Damian Day (Head of Education) led a brief session discussing the proposed approach to finalising the standards following the consultation and the other engagement which had been carried out on the proposals. This was discussed in more detail in the full Council meeting which followed.

3. **Recommendations**

The Council is asked to note the discussions from the July 2019 workshop.

[Author’s Name, Job Title]
General Pharmaceutical Council

[Enter date final version signed-off]
Meeting paper

Council on Thursday, 12 September 2019

Public business

GPhC Performance Report: Quarter 1 2019/20

Purpose
To report to Council on three areas of the organisation’s performance in Quarter 1 (April – June) 2019/20. This includes:

- Financial performance
- Progress against the annual plan; and
- Operational performance

Recommendations
The Council is asked to note and comment on:

i. the finance update provided at appendices 1 and 2

ii. the report on progress against the 2019/20 annual plan at appendix 3; and

iii. the operational performance information provided at appendix 4

1. Introduction
1.1. Prior to submission to Council, the content of these reports is reviewed by the Senior Leadership Group (SLG) operating as a Performance and Delivery Board with a focus on the budget and finance plan, monitoring the operational performance of the organisation and delivery against agreed plans. This allows a more pro-active and collective approach to be taken to emerging issues and supports a closer link to be made between delivering our regulatory responsibilities and dealing with operational challenges whilst continuing to deliver on strategic priorities. It also provides an opportunity to acknowledge where good progress is being made.

1.2. The section below provides a summary of key areas to note.

2. Summary: Key points
2.1. Some of the key areas to note in quarter 1 are as follows:
The agreed deficit budget for 2019/20 remains at £0.8m following the reforecast exercise carried out at the end of this quarter. £0.9m of the £1.2m efficiency savings has been identified and built into the initial budget. The revised £0.8m forecast deficit is based on the expectation that the full target will be reached.

There has been a small reduction in numbers of all three registrant groups this quarter. As a result, the assumed rate of growth for the number of registered pharmacists has been revised down, and a more conservative view on the growth of registered pharmacy technicians and premises has been used for our financial forecasting.

There have been no significant changes in the direction of travel of the five strategic priority areas outlined in the annual plan 2019/20 from the previous quarter (quarter 4, 2018/19). Three of the priority areas remain amber due to delays in planned activities, but currently remain achievable. The other two are on track and remain green. The annual plan represents an ambitious programme of work. Capacity is fully utilised and there is limited room for engaging in and managing any additional or unforeseen initiatives during the year.

Voluntary removals reduced by a third in this quarter compared to the proportions in the last two quarters. And there was an increase in the percentage of registrants successfully renewing their registration who were eligible by almost 5%

The rate of increase in the number of fitness to practise concerns received appears to have slowed. This will continue to be closely monitored. There have been considerable improvements in the time taken to triage concerns this quarter.

The number of routine inspections reduced this quarter as planned due to the implementation of the changed approach to inspections which started in April 2019. As a result, the number of pharmacies not inspected for over 36 months has increased.

KPIs for telephone abandonment rate and email responses were achieved, with the KPI relating to calls answered within 20 seconds falling slightly short in what was a busy quarter for the contact centre.

The stability rate (related to headcount) has continued to remain stable since the last quarter.

The following sections provide further detail on our performance relating to the three areas of (i) financial performance, (ii) progress against the annual plan, and (iii) operational performance.

3. Finance update

3.1. Appendices 1 and 2 provide the finance update for quarter 1. This follows a full reforecasting exercise which was carried out at the end of June 2019.

3.2. The 2019/20 financial plan currently remains in line with the initial budget remit. The savings and underspend that have emerged to date have only absorbed a reduction in income and the efficiency targets that were set at the start of the year. Therefore, no additional funds have been generated for new or unplanned pieces of work. Any new priorities that do emerge will therefore need to be prioritised within the existing budget envelope.
3.3. The total forecast income has decreased by £0.3m (1.3%) from £23.6m down to £23.3m. Whilst actual income received to date this year is as budgeted, a number of the initial budget income assumptions for the remainder of the year have been updated. Registrant numbers will continue to be monitored moving forwards.

3.4. The total forecast expenditure had decreased by £0.3m compared to the original budget, this relates on the whole to (i) targeted structural savings which will continue into future years, (ii) re-evaluation of one-off pieces of work, and (iii) lower than expected volumes in some statutory functions.

3.5. A significant amount of the targeted £1.2m efficiency savings (general £0.7m and IT 0.5m) have been identified.

3.6. The second reforecast exercise will take place in the autumn of this year with a further examination of the year to date actual spend and a critical assessment of what can be delivered in the remainder of the financial year.

4. Annual plan progress report

4.1. Appendix 3 reports on progress against the Annual Plan 2019/20. This is the first progress report to Council this year.

4.2. The annual plan 2019/20 sets out the key areas of work under the five strategic priority themes of:

- Building our data and insight capability
- Developing a proportionate and restorative approach to fitness to practise
- Implementing our approach to regulating registered pharmacies
- Setting and upholding standards
- Operating as a professional, lean organisation

4.3. Although in some cases worded slightly differently most of the strategic priorities in 2019/20 are a continuation of those set out in 2018/19 (as it had been in the previous year from 2017/18, albeit with the addition of developing our approach to fitness to practise). This approach reflects an emerging intent to move away from short-term year-to-year planning, instead taking a much longer-term view of our priorities, planning and resources. It also explains why we have reported on our direction of travel as a continuation from quarter 4 of 2018/19.

4.4. In addition, in light of the increasing pace of change in pharmacy, we signalled our work to develop a 10-year vision. The Annual Plan 2019/20 therefore represents a transitional period as we continue to set our longer-term goals and develop our plans to achieve these.

4.5. This is whilst we continue to deliver our regulatory responsibilities, including setting the standards for pharmacy professionals and pharmacies to enter and remain on the register, maintaining a register of
those who meet these standards and investigating concerns about the people or pharmacies we register. In addition, we are continually seeking opportunities to improve how we deliver these responsibilities.

4.6. Council first reviewed the 2019/20 annual plan reporting template at its meeting in February when for the first time it accompanied the draft annual plan. At the time, it was noted that setting this out in this detail at an earlier stage increased cross working between teams and a better understanding of organisational wide capacity, linkages and sequencing of work. The content of the plan was also underpinned by a more detailed understanding of the wider costs for each activity which informed the 2019/20 budget.

4.7. As part of our reporting, we are continuing to hold ourselves to account to the original draft outline activities and timelines, as presented in February. This should provide transparency on how we have progressed against the timetable we set ourselves for the annual plan year; where we have proceeded in accordance with the timetable; those areas where we have fallen behind or where we might be ahead of where we thought we would be. Whilst activities may have progressed since quarter 1, reporting remains focused on this period as part of good governance and so that this aligns with reporting mechanisms and timescales elsewhere.

4.8. We have looked to link more closely the high-level activities under each strategic priority, with the outline timetable and commentary provided. Where we make amendments to our timetabled activities, or review and update our key links, assumptions and risks we will indicate this, where relevant. This should encourage more strategic reporting rather than recitation of activities.

4.9. The RAG status of each of the strategic priorities is reviewed and collectively agreed by the Senior Leadership Group, when operating in a Performance and Delivery Board mode.

4.10. Status of work in this quarter is as follows:

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Status</th>
<th>Direction of travel</th>
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<tbody>
<tr>
<td>Building our data and insight capability</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Developing a proportionate and restorative approach to fitness to practise</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Implementing our approach to regulating registered pharmacies</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Setting and upholding standards</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Operating as a professional, lean organisation</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>
4.11. The following paragraphs provide further explanation on the RAG statuses above.

4.12. Building our data and insight capability – this status remains the same, amber, from the previous quarter. This is due to continued delays to completing some scheduled GDPR related activities and slower progress on development of the balanced scorecard due to limited capacity while dealing with business as usual activities and recruitment. Some roles have now been filled and work has started on these activities.

4.13. Developing our approach to fitness to practise – this status remains the same, amber, from the previous quarter as we are not fully on track with the key pieces of work highlighted in Q1 of the outline timetable, although we expect that the key deliverables scheduled to take place further in the year are still achievable.

4.14. Implementing our approach to regulating registered pharmacies – this status remains the same, green, from the previous quarter and reflects the overall positive progress made in this priority area.

4.15. Setting and upholding standards – this status remains the same, green, from the previous quarter reflecting the fact that key pieces of work associated with the delivery of this priority area remain on schedule.

4.16. Operating as a professional, lean organisation – this status remains the same, amber, from the previous quarter as the EDI strategy work remains behind schedule although action is being taken to address this as outlined in the report.

4.17. We are continuing to ensure closer links between the content of the annual plan progress report, the performance monitoring report and our budget and finance plans to reflect the fact that we need to continue to meet our regulatory responsibilities and deal with operational challenges, whilst still looking to deliver against our strategic priorities.

4.18. Setting out what success looks like as an integral part of the annual plan supports a wider change in our culture towards all being clearer what success will look like, in line with our culture statement.

5. Performance Monitoring Report

5.1. Appendix 4 reports on the operational and financial performance of the organisation. It is the first progress report to Council this year.

5.2. The following paragraphs provide some further narrative around the sub-points above (in the Summary: Key points section):

**Customer contact centre**

5.3. Over 11,000 calls were received to the contact centre this quarter, 73.2% were answered within 20 seconds. The calls were mainly related to: renewal and revalidation for the renewal cohorts going through revalidation for the first time on the new basis, revalidation review and feedback as we begin to review records on the new basis, peer review and reflective accounts for the first cohort due to submit, pre-registration queries for new applicants joining the 2019/20 scheme, the new online services and registration assessment queries.

**Revalidation and renewal**

5.4. During quarter 1, 19,969 were required to renew their registration and submit revalidation records. 97.6% of registrants in this cohort successfully renewed their registration which is an increase of by almost 5% on
the last quarter. 99.4% of registrants who renewed also successfully submitted complete revalidation submissions.

**Fitness to practise**

5.5. The number of concerns triaged within five working days has considerably improved from 45.4% in the last quarter to 64.2% this quarter with the concerns team fully staffed and better able to anticipate initial inquiries following the introduction of an oversight panel at the end of Q3 2018/19. The proportion of concerns closed at triage has increased for the third consecutive quarter to 49.1% this quarter. This increase is due to several factors including greater use of regulatory levers such as passing soft intelligence to Inspectorate colleagues and other agencies, senior support through oversight allowing concerns to be appropriately closed at triage which previously would have been referred for investigation, and increased productivity from being fully staffed.

**Inspection**

5.6 The number of routine inspections over the period decreased from 883 in the last quarter to 751 this quarter. This was a planned reduction due to implementing the updated approach to inspection in April, including ongoing training for inspectors and an increased number of closures of fitness to practise cases at Stream 1. There has been an increase in the number of pharmacies not inspected for over 36 months from 3,200 to 3,408 (6.5%). This results from a number of factors including the lower number of routine inspections undertaken and historical spikes in inspection activity.

**Human resources**

5.6. The voluntary turnover rate for permanent staff has decreased from the previous quarter (January to April 2019) from 7.4% to 5.0% where career progression, pay and workload remain the key reasons for leaving. With regard to headcount, the stability rate (based on the number of permanent employees with more than 12 months employment at the GPhC) has remained on par with the last quarter at 84%.

6. **Equality and diversity implications**

6.1. Our aim is to embed equality, diversity and inclusion in both our role as a regulator and an employer.

6.2. One of our key activities is to develop an updated comprehensive Equality, Diversity and Inclusion strategy with a focus on our regulatory functions. We will continue to look at how we can monitor, demonstrate and report on our progress towards this aim.

7. **Communications**

7.1. The development and publication of this report is reflective of our commitment to openness and transparency concerning our performance.

7.2. We continue to carry out specific communications on each of the areas of reported performance. This includes information on our website, wider communications through the media and directly through our own publications and communications materials. These activities are designed to reach all our key interest groups including patients and their representatives, pharmacy professionals and their employees, education providers and others.
7.3. Internal communications on our annual plan including the detail that sits underneath will be important as we go through a period of change. There have been transparent and specific communications around key stages of activities within the plan to inform and engage with staff, including relevant content on the staff intranet.

8. **Resource implications**

8.1. Resource implications are addressed within the report.

8.2. The allocation of resources required to progress with the annual plan as well as delivering our statutory responsibilities continues to be a key consideration including in developing proposals for the 2020/21 budget and future fee arrangements.

8.3. We will continue to monitor our resource capacity to deliver our statutory responsibilities, progress the annual plan, whilst ensuring capacity to respond to unforeseen events and deal with work reactionary in nature.

9. **Risk implications**

9.1. The strategic risk register will continue to be reviewed as part of our management framework and risks will be recorded and reviewed in relation to our work.

9.2. Any significant decrease in registrant numbers could lead to a lower income rate than expected.

9.2. A failure to identify the remaining £0.3m efficiency savings could leave an equivalent gap in the financial plan unless it is offset by in year underspend elsewhere.

9.3. Main risks associated with the delivery of the annual plan are included as part of the annual plan progress report.

9.4. With regards to operational performance, failure to maintain an accurate register and/or carry out our other regulatory functions efficiently and effectively could have implications on patient safety, and a significant impact on the GPhC’s reputation.

10. **Monitoring and review**

10.1. Council will receive a performance report on a quarterly basis, providing a financial update, an overview of the delivery of the GPhC’s regulatory functions and progress made against the annual plan.

10.2. As highlighted earlier in this paper, the Senior Leadership Group now convenes as a Performance and Delivery Board reviewing financial performance as well as the content of both the performance monitoring report and annual plan progress report, on a quarterly basis prior to Council.

8.3 We continue to be mindful of and look to feed in learning from planning and reporting previously as part of our commitment to continuous learning and improvement.
**Recommendations**

The Council is asked to note and comment on:

i. the finance update provided at appendices 1 and 2

ii. the report on progress against the 2019/20 annual plan at appendix 3; and

iii. the performance information provided at appendix 4

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General Pharmaceutical Council

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Tel 020 3713 7805
Quarter one – Finance update

Purpose

This paper provides an update on the GPhC’s 2019/20 financial plan following the quarter one reforecasting exercise including a summary of:
- the revised financial forecast for the year
- the most significant movements in income and expenditure
- the main financial risks and opportunities that remain for the year

1. Forecast changes to the 2019/20 budget.

1.1 A full reforecasting exercise was carried out at the end of June 2019, incorporating actual financial results for the first quarter and an updated budget forecast for the remaining nine months to the end of the financial year.

1.2 The agreed budget for 2019/20 was finalised at a deficit of £0.8m. The net result of all the movements following the reforecasting exercise is that the deficit for 2019/20 remains at £0.8m. A projected £0.3m fall in income for the year has been offset by a similar reduction in expenditure across the business. A full summary of the quarter one income and expenditure position is provided in Appendix one.

1.3 The GPhC has identified £0.9m of the £1.2m efficiency savings that were built into the initial budget and the revised £0.8m forecast deficit is based on the expectation that the full target will be reached.

1.4 Whilst the GPhC is still forecasting a £0.8m deficit for the year, the actual position at the end of the first quarter is £0.6m ahead of the expected deficit budget position for that point in the year (as shown in Appendix two). This is predominantly due to slower than anticipated expenditure as result of:

- reduced employee costs from both delays in recruitment and the delivery of the targeted efficiency savings
- reduced spend on committees and associates. A contributing factor is due to a lower volume of hearing days than anticipated being held in the first quarter of the year
- reduced IT costs relating to rescheduling of IT related work

1.5 The status of the year to date actual expenditure will be monitored and reviewed alongside the GPhC’s delivery of the annual plan at the quarter two reforecast. If expenditure continues to lag at that point it could result in an improved financial outlook for the 2019/20 financial year and a lowering of the projected deficit.
1.6 Following the reforecast, the projected end of year cash and free reserves balances are expected to be £25.1m and £6.9m by the end of the financial year (as shown in Appendix three).

2. Income

2.1 Total forecast income has decreased by £0.3m (1.3%) from £23.6m down to £23.3m. Whilst actual income received to date this year is as budgeted, the GPhC has updated a number of the initial budget income assumptions for the remainder of the year.

2.2 The assumed rate of growth for the number of registered pharmacists for the year has been revised down. This reflects the slightly lower number (182) of actual registrants up to June and to anticipate the impact of a reduction in the number of new pharmacists joining the register resulting from the lower pass rate from the June registration exam.

2.3 A more conservative view on the growth of registered pharmacy technicians and premises has also been taken with growth rates adjusted to zero-growth for the year (down from 1% and 0.3% respectively) to reflect the current static registrants’ numbers in both groups.

2.4 A small adjustment has been made in relation to the 2019 fee increase (that was effective from July 2019) to ensure the income forecast to be received this financial year is more accurately aligned to the current renewal dates. Further data insight and intelligence is being sought around the trends in registrant numbers to inform both the quarter two reforecast and 2020/21 budgeting assumptions.

2.5 The downward revision of the above income assumptions has been slightly offset by a small increase in cost recovery income from accreditation events. With a small number of delayed events from the previous year and several additional events expected to take place later in the year.

2.6 Further data insight and intelligence is being sought around the trends in registrant numbers to inform both the quarter two reforecast and 2020/21 budgeting assumptions.

3. Expenditure

3.1 The total forecast expenditure has decreased by £0.3m compared to original budget. The reductions in expenditure essentially fall in to three main categories:

- Targeted structural savings which will continue into future years
- Re-evaluation of one-off pieces of work with decisions to either not go ahead, delay or deliver in a different way
- Lower than expected volumes in some statutory functions have delivered savings during the first quarter which have been recognised

3.2 A summary of the most significant changes in the financial plan is provided as follows:

<table>
<thead>
<tr>
<th>Cost category</th>
<th>Value</th>
<th>Principle reasons for movements</th>
</tr>
</thead>
</table>
4. **Efficiency savings**

4.1 As previously stated, a significant amount of the targeted £1.2m efficiency savings (general £0.7m and IT £0.5m) has been identified. £0.54m of these savings relate to structural headcount savings which have been identified and actioned from departments across the business, including a number of roles that have been either been disestablished or changed since the budget was agreed.

4.3 In addition to the structural related headcount savings that have been identified, there has been further in year savings generated from a higher than expected vacancy rate. A vacancy factor of 4% was included as part of the initial budget to account for roles not all being filled 100% of the time. The actual vacancy rate is currently running at between 6% and 7%. As part of the updated forecast the vacancy rate going forward for the remainder of the year has been increased to 5% to bring this more in line with the current state.

4.4 A cost reduction target of £0.47m was also included in the IT budget. £0.36m of this target has been achieved with £0.10m still to be realised. The savings so far have been achieved through:

<table>
<thead>
<tr>
<th>Employee costs: Payroll</th>
<th>£0.73m</th>
<th>£545K relates to structural savings identified as part of efficiency target. Delays in recruitment with a number of roles not being filled at the end of quarter one</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT development costs</td>
<td>£0.27m</td>
<td>Savings in IT development due to delaying some pieces of work and moving work to an outsourced provider</td>
</tr>
<tr>
<td>Council and committee</td>
<td>£0.15m</td>
<td>Lower number of FtP hearing days during quarter one and re-phasing of the revalidation review timings</td>
</tr>
<tr>
<td>Employee costs: Other</td>
<td>£0.08m</td>
<td>Savings to date with recruitment delays and a lower number of roles being recruited by external agencies. Group training for newly appointed case officers will now be a mixed approach with more taking place internally over a longer period of time.</td>
</tr>
<tr>
<td>Event costs</td>
<td>£0.07m</td>
<td>Reduced number of external stakeholder events and reduced catering costs associated with a lower number of committee days.</td>
</tr>
<tr>
<td>Legal costs</td>
<td>£0.05m</td>
<td>Savings due to lower utilisation of external panel firms to date.</td>
</tr>
<tr>
<td>Contingency</td>
<td>(£0.94m)</td>
<td>Efficiency target set during budget setting - identified efficiencies have been allocated to appropriate cost line.</td>
</tr>
<tr>
<td>Professional costs</td>
<td>(£0.1m)</td>
<td>Consultancy costs have increased with a few pieces of work carrying over from the previous financial year. These include the development of the investment strategy, support around the online inspection reports and strategic accommodation review. In most cases the additional cost has been offset against reductions in various other cost lines.</td>
</tr>
<tr>
<td>Building and occupancy costs</td>
<td>(£0.05m)</td>
<td>We provided for a rent increase at a minimum level. However, the actual increase will be slightly above projection.</td>
</tr>
<tr>
<td>Financial costs</td>
<td>(£0.02m)</td>
<td>Bank charges in relation to payments received are higher than expected due to increased rates.</td>
</tr>
<tr>
<td>PSA levy costs</td>
<td>(£0.02m)</td>
<td>The PSA levy was increased after the loss of income from PSA tenants.</td>
</tr>
</tbody>
</table>
• Reduction of specific costs after review of services and benefits realisation of development projects. These are mainly around services which have moved to the cloud platform and no longer require on premise support costs and form part of the managed service contract

• Evaluation of one-off pieces of work and how these can be delivered in-house and not externally. Proposed development work around IT security £51K is now being delivered by internal resources. Costs associated with changing managed service provider (£0.17m) and updates to the organisation website (£0.07m) have been postponed to future years and are currently being managed through contract extensions with existing providers

• Review of contracts to make these more competitive. The Microsoft licences renewal costs were expected to increase by £0.13m. By reviewing our licence packages and actual working arrangements, an alternative option was selected and the increase in cost was reduced to £0.03m. Savings were also achieved in costs around mobile phones, broadband and audio-visual support

4.5 The remaining IT cost reduction target is anticipated to be met in the coming months via continued review of existing contracts and the movement of further IT services to the Cloud platform. Any additional IT costs pressures that emerge during the year are expected to be absorbed within the current expense envelope.

5. **Risks and opportunities**

5.1 There are a number of potential financial risks and opportunities that have been identified that could emerge over the remainder of the financial year which are summarised below.

5.2 Registrant numbers are marginally lower than expected in the first quarter of the year and there is a risk that this could continue if more registrants choose to leave the register in the coming busy renewal months, thereby leading to an even lower income growth rate than expected.

5.3 A greater reliance on temporary staffing arrangements to cover permanent vacancies could increase costs and offset the financial benefits of the higher vacancy rate.

5.4 The development of a strategic enquiry hub to has been identified as a strategic priority which will need to be explored and resourced if it is to go ahead.

5.5 A failure to identify the remaining £0.3m efficiency savings would leave an equivalent gap in the financial plan unless it is offset by in year underspend elsewhere.

5.6 Additional costs saving opportunities are possible aside from those already built into the budget. These savings are dependent on probabilities which will become clearer in the next few months. The three main areas that could see lower than anticipated costs are:

  • Hearing costs (fewer hearings taking place)
  • Panel firms (if more cases are dealt with in house)
  • Revalidation reviews with adjusting the timings for reviews especially around peak renewal periods
6. **Conclusion**

6.1 The 2019/20 financial plan currently remains in line with the initial budget remit. The savings and underspend that have emerged to date have only absorbed a reduction in income and the efficiency targets that were set at the start of the year. Therefore, no additional funds have been generated for new or unplanned pieces of work. Any new priorities that do emerge will need to be prioritised within the existing budget envelope.

6.2 The second reforecast exercise will take place in the autumn of this year with a further examination of the year to date actual spend and a critical assessment of what can be delivered in the remainder of the financial year.

6.3 If this results in a lower deficit being forecast following the quarter two review, this money should be retained as reserves to help improve the underlying financial position. This is crucial as the GPhC needs to prioritise replenishing the levels of reserves held over the coming years (as they are projected to fall to close to the minimal acceptable level). This is to ensure the organisation has an appropriate level of financial headroom and flexibility to manage unexpected events and invest in necessary initiatives in the years to come.

Jonathan Bennetts
Associate Director of Finance and Procurement
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### Appendix 1

#### Summary Income and Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2019/2020 Reforecast one £000's</th>
<th>2019/2020 Budget £000's</th>
<th>2019/2020 Variance £000's</th>
<th>2019/2020 Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist income</td>
<td>15,272</td>
<td>15,461</td>
<td>(189)</td>
<td>(1.2%)</td>
</tr>
<tr>
<td>Premises income</td>
<td>3,753</td>
<td>3,904</td>
<td>(151)</td>
<td>(3.9%)</td>
</tr>
<tr>
<td>Pharmacy technician income</td>
<td>2,991</td>
<td>3,015</td>
<td>(24)</td>
<td>(0.8%)</td>
</tr>
<tr>
<td>Pre-registration income</td>
<td>1,119</td>
<td>1,116</td>
<td>4</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other income</td>
<td>199</td>
<td>157</td>
<td>42</td>
<td>26.7%</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>23,334</td>
<td>23,652</td>
<td>(318)</td>
<td>(1.3%)</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total employee costs: Payroll</td>
<td>13,039</td>
<td>13,773</td>
<td>734</td>
<td>5.3%</td>
</tr>
<tr>
<td>Total employee costs: Other</td>
<td>1,008</td>
<td>1,094</td>
<td>86</td>
<td>7.9%</td>
</tr>
<tr>
<td><strong>Total employee costs</strong></td>
<td><strong>14,046</strong></td>
<td><strong>14,867</strong></td>
<td><strong>821</strong></td>
<td><strong>5.5%</strong></td>
</tr>
<tr>
<td>Total committee and associate costs</td>
<td>2,301</td>
<td>2,454</td>
<td>153</td>
<td>6.2%</td>
</tr>
<tr>
<td>Total professional costs</td>
<td>1,010</td>
<td>915</td>
<td>(95)</td>
<td>(10.4%)</td>
</tr>
<tr>
<td>Total legal costs</td>
<td>672</td>
<td>726</td>
<td>53</td>
<td>7.3%</td>
</tr>
<tr>
<td>Total IT costs</td>
<td>1,845</td>
<td>2,116</td>
<td>272</td>
<td>12.8%</td>
</tr>
<tr>
<td>Total event costs</td>
<td>430</td>
<td>499</td>
<td>70</td>
<td>14.0%</td>
</tr>
<tr>
<td>Total office costs</td>
<td>382</td>
<td>388</td>
<td>5</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total property cost</td>
<td>301</td>
<td>315</td>
<td>14</td>
<td>4.5%</td>
</tr>
<tr>
<td>Total service level and occupancy</td>
<td>2,233</td>
<td>2,178</td>
<td>(55)</td>
<td>(2.5%)</td>
</tr>
<tr>
<td>Total financial cost</td>
<td>174</td>
<td>154</td>
<td>(20)</td>
<td>(13.2%)</td>
</tr>
<tr>
<td>Total depreciation</td>
<td>970</td>
<td>977</td>
<td>7</td>
<td>0.7%</td>
</tr>
<tr>
<td>Total other costs</td>
<td>42</td>
<td>41</td>
<td>(1)</td>
<td>(2.2%)</td>
</tr>
<tr>
<td>PSA levy costs</td>
<td>217</td>
<td>202</td>
<td>(15)</td>
<td>(7.5%)</td>
</tr>
<tr>
<td>Contingency</td>
<td>(287)</td>
<td>(1,228)</td>
<td>(941)</td>
<td>76.6%</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>24,335</td>
<td>24,602</td>
<td>268</td>
<td>1.1%</td>
</tr>
<tr>
<td>Interest and tax</td>
<td>160</td>
<td>142</td>
<td>17</td>
<td>12.3%</td>
</tr>
<tr>
<td><strong>Net operating surplus/(deficit) after interest and tax</strong></td>
<td><strong>(841)</strong></td>
<td><strong>(808)</strong></td>
<td><strong>(33)</strong></td>
<td><strong>4.1%</strong></td>
</tr>
</tbody>
</table>
The graph shows cumulative financial position (surplus/(deficit)) for budget, actuals and forecast. The first quarter to June 2019 compares actual surplus/(deficit) position to budget whilst the rest of the year (July 2019 to March 2020) compares forecast to the original budget.
Reserves

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>General free reserves</td>
<td>7,254</td>
<td>6,893</td>
</tr>
<tr>
<td>Fixed asset reserves</td>
<td>3,879</td>
<td>3,399</td>
</tr>
<tr>
<td>Total Reserves</td>
<td><strong>11,133</strong></td>
<td><strong>10,292</strong></td>
</tr>
</tbody>
</table>

No. of month’s operating expenditure based on free reserves

3.8  3.4

In line with the predicted deficit for the financial year. The number of months of free reserves is expected to fall to 3.4m, which is still above the agreed minimum level of reserves. As expected Fixed Assets will depreciate over time and the projected forecast has been updated to account for this and any further capital expenditure for the year.

Investments to 30/06/2019

<table>
<thead>
<tr>
<th>Bank Name</th>
<th>Invested Funds %</th>
<th>Balance</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldman Sachs</td>
<td>11</td>
<td>2,688,339</td>
<td>Variable</td>
</tr>
<tr>
<td>Natwest Business</td>
<td>5</td>
<td>1,290,282</td>
<td>Variable</td>
</tr>
<tr>
<td>Santander</td>
<td>20</td>
<td>5,000,000</td>
<td>1.1</td>
</tr>
<tr>
<td>Nationwide Business</td>
<td>20</td>
<td>5,068,167</td>
<td>1.1</td>
</tr>
<tr>
<td>Lloyds</td>
<td>20</td>
<td>5,000,000</td>
<td>1.25</td>
</tr>
<tr>
<td>Barclays</td>
<td>20</td>
<td>5,000,000</td>
<td>0.91</td>
</tr>
<tr>
<td>Handelsbanken</td>
<td>4</td>
<td>1,000,403</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25,047,190</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annual plan progress report 2019/20

Quarter 1: April – June 2019
Introduction

This report sets out the key strategic priorities in our Annual plan 2019/20.

The reporting period covers quarter 1, April to June 2019.

Overview

<table>
<thead>
<tr>
<th>Strategic Priorities</th>
<th>Status</th>
<th>Direction of travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building our data and insight capability</td>
<td>A</td>
<td>⬤</td>
</tr>
<tr>
<td>Developing a proportionate and restorative approach to fitness to practise</td>
<td>A</td>
<td>⬤</td>
</tr>
<tr>
<td>Implementing our approach to regulating registered pharmacies</td>
<td>G</td>
<td>⬤</td>
</tr>
<tr>
<td>Setting and upholding standards</td>
<td>G</td>
<td>⬤</td>
</tr>
<tr>
<td>Operating as a professional, lean organisation</td>
<td>A</td>
<td>⬤</td>
</tr>
</tbody>
</table>
### Building our data and insight capability

#### Strategic aim:
- The pharmacy team have the necessary knowledge, attitudes and behaviours
- Registered pharmacies deliver safe, effective care and services
- Pharmacy regulation is efficient and effective

#### In 2019/20 we will:
- Continue to update our data, approach and procedures to ensure compliance with data protection legislation
- Develop a strategic engagement and research programme
- Develop a strategic approach for how we will systemically evaluate the impact of our work going forwards
- Start to report more broadly on our performance based on good quality and sustainable data sources
- Develop and implement an intelligence model for managing incoming information
- Develop a broader range of information for collection to support proactive and intelligence informed actions
- Invest in the scoping of a whole-organisation approach to managing incoming enquiries about pharmacy

#### What does success look like?
- People trust us to use their data fairly and responsibly
- Our research and engagement activities are well planned and driven by our strategy
- We understand the quality, efficiency, costs and impact of our work
- All key governance and management performance monitoring reports are standardised and automated
- We are clear how we act on intelligence
- We understand what information is important and where to get it from
- We have a clear framework guiding our phased development work for a whole organisation approach to enquiries

#### Key links and assumptions
- Information governance work links to all priorities and data protection work will be embedded in projects where changes to the way we collect and use personal data are proposed
- The volume of data and information requests remains stable so that there is capacity to do improvement work
- Resources for all business teams are available to do this work and teams will work collaboratively with support from senior leaders and managers

#### Main risks
- If resources (capacity and capability) are not available in business teams or partner organisations, work will take longer to complete
<table>
<thead>
<tr>
<th>April-June 2019 (Q1)</th>
<th>July-September 2019 (Q2)</th>
<th>October-December 2019 (Q3)</th>
<th>January-March 2020 (Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Annual refresher data protection training for all staff and associates</td>
<td>• Scoping for records management development work</td>
<td>• Review of document storage</td>
<td>• Evaluate progress on records management</td>
</tr>
<tr>
<td>• Focussed data protection training programme for specific functions commences</td>
<td>• Review of document storage</td>
<td>• Consider results of registrant workforce survey and develop action plan</td>
<td>• Scoping for next phase of records management development work and review document management options</td>
</tr>
<tr>
<td>• Personal data processing records reviewed and updated</td>
<td>• Registrant workforce survey finalised and reported on</td>
<td>• Develop budget and resource proposals for future evaluation work</td>
<td>• Continued development and phased implementation of the balanced scorecard/MI reports</td>
</tr>
<tr>
<td>• Develop records management strategy</td>
<td>• Develop and agree an evaluation approach and programme of work</td>
<td>• Continued development and phased implementation of the balanced scorecard/MI reports</td>
<td>• Agree plan and requirements for additional data collection</td>
</tr>
<tr>
<td>• Conduct a registrant workforce survey</td>
<td>• Continue development of a balanced scorecard and themed insight reports</td>
<td>• Draft engagement and research strategy and medium-term programme</td>
<td>• Engagement and research strategy and programme in place and operational</td>
</tr>
<tr>
<td>• Produce a logic model for the whole organisation’s work which will help design a consistent approach to evaluation</td>
<td>• Scope engagement and research strategy and medium-term programme</td>
<td>• Draft engagement and research strategy and medium-term programme</td>
<td>• Prepare for implementation of the evaluation programme</td>
</tr>
<tr>
<td>• Continued standardisation and consolidation activities for data to improve data quality</td>
<td>• Develop intelligence model and criteria for managing and acting on incoming information</td>
<td>• Begin to scope requirements for additional data collection</td>
<td>• Programme for additional data to be collected commences</td>
</tr>
<tr>
<td>• Begin development of a balanced scorecard and KPIs to report on our performance</td>
<td>• Develop plan and identify datasets to collect and why, and develop a plan to collect it</td>
<td>• Test the intelligence model for managing and acting on incoming information</td>
<td>• Refine and fully operationalise intelligence model</td>
</tr>
<tr>
<td>• Develop logic model for whole-organisation approach to managing potential concerns</td>
<td>• Prepare draft proposal for managing potential concerns using a new approach with clear evaluation measures</td>
<td>• Develop phased plan, budget and resource proposals for new approach to managing potential concerns</td>
<td>• Prepare for next phase of trialling and phased implementation of a new whole organisation approach to managing potential concerns</td>
</tr>
</tbody>
</table>
Commentary:

The overall RAG status is **amber** due to continued delays to completing some scheduled GDPR related activities and slower progress on development of the balanced scorecard due to limited capacity while dealing with business as usual activities and recruitment. Some roles have now been filled and work has started on these activities.

Continue to update our data, approach and procedures to ensure compliance with data protection legislation

There has been mixed progress in the four timetabled activities relating to this priority workstream this quarter. Three are amber, with one not yet started. In relation to annual data protection and information security refresher training, E-learning for 2019/20 has been selected, tested and set up for launch, which is scheduled in July. Launch was postponed from Q1 to avoid conflict with health and safety e-learning. E-learning for associates has been planned for the autumn after new members join. Further specialist team training has been developed and a pilot session arranged with HR for July before rolling out to other teams in the autumn. Records management activities started at the end of June when team resources became available. This includes work on personal data processing records which has now been rescheduled for Q2-3.

Develop a strategic engagement and research programme

In relation to the timetabled activity under this priority workstream this quarter progress has been positive. The registrant survey was successfully launched for our registered pharmacists and pharmacy technicians this quarter in June. The survey questionnaire was updated from the last 2013 survey with significant input from key stakeholders. Some questions were retained to enable comparisons to be made, others were updated to ensure they reflected current practice and sectors. Additional questions were added to include job satisfaction, work life balance, workforce movement and questions were expanded on equality, diversity and inclusion.

Develop a strategic approach for how we will systematically evaluate the impact of our work going forwards

There has been slower progress in relation to the two timetabled activities this quarter. Whilst we have undertaken some initial exploration of how a logic model approach could be utilised across the organisation to provide a consistent approach to evaluation, more work is needed to ensure any final approach is proportionate and flexible. Work on this will continue now into the next two quarters. In the meantime, however, the logic model for the regulation of registered pharmacies has been updated to reflect the updates to our approach which went live in April. This will now be used to frame the evaluation of the changes, which has been programmed for 2021. The activity to develop a logic model for the whole approach to managing potential concerns has been incorrectly scheduled as this will flow from the trialling of the approach scheduled for Q4.

Start to report more broadly on our performance based on good quality and sustainable data sources

Progress has been mixed in the two timetabled activities under this priority workstream this quarter, with one green and one amber. In relation to the standardisation and consolidation for data to improve quality activity, a data quality policy was approved in April. This makes clear everyone’s responsibilities with regard to data quality and links to our draft 10-year vision, culture and behavioural framework. Directorates are working on its
implementation into everyday operations. In relation to beginning the development of a balanced scorecard, we have started developing this as a pilot in one directorate before rolling out to other areas. In doing so, it is clear that this is a more complex and challenging concept for teams to get used to and understand than originally envisaged. In addition, timing has coincided with some other key workstreams around getting ready for going live with publication of inspection reports in particular. Whilst we have made some progress in developing prototypes of reports at operational levels for some teams, more work is required to finalise reporting at other levels.

**Develop and implement an intelligence model for managing incoming information**
There are no timetabled activities under this workstream this quarter.

**Develop a broader range of information for collection to support proactive and intelligence informed actions**
There are no timetabled activities under this workstream this quarter.

**Invest in the scoping of a whole-organisation approach to managing incoming enquires about pharmacy**
There are no timetabled activities under this workstream this quarter.
## Developing a proportionate and restorative approach to fitness to practise

**Strategic aim:** The pharmacy team have the necessary knowledge, attitudes and behaviours

### In 2019/20 we will:
- Develop and engage on a strategy for a proportionate and restorative approach to fitness to practise
- Design an approach to managing health issues that supports registrants back into practice where appropriate
- Improve the way we communicate with everyone involved throughout the fitness to practise process
- Improve our understanding of the unintended impact of the fitness to practise process on everyone involved in the process

### What does success look like?
- We achieve a high level of engagement during the development of our future FtP strategy
- The future FtP strategy is drafted, reflects the learning from recent reports and inquiries into health regulation and is ready for consultation
- A revised process for managing health issues that supports registrants and only uses our fitness to practise process where there is a risk to the ongoing health of the registrant’s or public safety
- We will have identified the key changes we would like to make to our communications and have a plan to embed these throughout our fitness to practise process
- We have a clear plan in place to minimise the unintended impact of fitness to practise processes identified

### Key links and assumptions
- We have the policy and quality assurance resource to be able to deliver the strategy development and associated service improvements (updated for Q1 reporting)
- We have the resources and capability to engage meaningfully with stakeholders during the development phase
- We continue to learn from other regulators in our sector and adopt good practice, particularly from those who have reviewed their approach to FtP
- We will need to be responsive to any changes in the regulatory landscape

### Main risks
- The volume of concerns continues to rise meaning that resources are diverted away from strategy development to operations
- We are unable to recruit to key senior posts and cannot retain our existing staff
- Mismatch between different stakeholders’ appetites for change, the developing direction of the strategy and our objective to protect patients and the public
### Outline timetable:

<table>
<thead>
<tr>
<th>April-June 2019 (Q1)</th>
<th>July-September 2019 (Q2)</th>
<th>October-December 2019 (Q3)</th>
<th>January-March 2020 (Q4)</th>
</tr>
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<tbody>
<tr>
<td>• Agree strategy development engagement plan</td>
<td>• Start main strategy development engagement</td>
<td>• Report on approach to managing health concerns</td>
<td>• Develop and agree FtP strategy consultation process</td>
</tr>
<tr>
<td>• Introduce revised FtP case categories to improve understanding of concerns profile</td>
<td>• Assess how we currently manage health cases through the FtP process</td>
<td>• Evaluate effectiveness of new FtP categories</td>
<td>• Finalise report to Council on engagement and draft strategy for consultation</td>
</tr>
<tr>
<td>• Evaluate the impact and effectiveness of senior management oversight of triage process</td>
<td>• Develop options for managing health cases and engage with stakeholders</td>
<td>• Report on outcomes and actions from the FtP review to understand the unintended impact on everyone involved throughout the ftp process</td>
<td>• Embed our agreed approach to managing health concerns</td>
</tr>
<tr>
<td>• Initiate a comprehensive review of the FtP process to understand its unintended impact on everyone involved throughout the ftp process</td>
<td>• Evaluate effectiveness of threshold criteria (introduced Feb 2018)</td>
<td>• Agree student FtP guidance</td>
<td>• Action final recommendations from impact review work including in-house changes and those that influence future strategy</td>
</tr>
<tr>
<td>• Engage with stakeholders on student FtP guidance</td>
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<td>• Launch new student ftp guidance</td>
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</table>
Commentary:

The overall RAG status is amber as we are not fully on track with the key pieces of work highlighted in Q1 of the outline timetable, although we expect that the key deliverables scheduled to take place further in the year are still achievable.

Develop and engage on a strategy for a proportionate and restorative approach to fitness to practise
This work to develop the fitness to practise strategy is on track. The engagement was agreed in Q1. Key stakeholders in the FtP process have been identified and will be involved in events and meetings to gather their views. The stakeholders include: registrant and their representatives, patient groups, staff, employers, other regulators and concerns handling organisations. Engagement is now ongoing in Q2.

Progress on work to introduce revised FtP allegation categories has been slow. The categories, which will better differentiate between types of concern have been agreed. Implementation work has begun as part of wider work to improve data quality and stewardship. The work will not complete until the end of Q2 now.

The progress to evaluate the impact of senior management oversight of triage is mixed. An evaluation was carried out as planned in Q1. The evaluation demonstrated positive impacts on resolving potential stream 2 cases either by collecting information to advance stream 2 cases more promptly or through using resources across the organisation to resolve concerns (such as the education complaints process). We have extended the period of senior oversight for a further quarter in order to collect more evidence to inform future work, including the scoping of a whole organisation approach to managing incoming enquiries about pharmacy. During this next phase, we’re including the views of Regional Managers from the Inspectorate and are better recording opportunities for learning from resolving concerns. We will further evaluate the impact of our approach in Q3.

Design an approach to managing health issues that supports registrants back into practice where appropriate

There were no timetabled activities scheduled for Q1. In preparation for activities in Q2, an internal working group has been formed.

Improve the way we communicate with everyone involved throughout the fitness to practise process

There were no timetabled activities scheduled for Q1. An internal working group responsible for improving our customer service started a review of our customer interactions with the view to produce recommendations in Q2.
**Improve our understanding of the unintended impact of the fitness to practise process on everyone involved in the process**

The work to undertake a comprehensive review of the FtP process to understand its unintended impact has not yet started and is now due to progress in Q2. Work will initially involve the development of a logic model of the FtP process which can be used to understand both the intended and unintended consequences of the process. The overall project will still complete as planned in Q3.

**Develop and publish guidance on student FtP**

This timetabled activity is on track. The fitness to practise policy team is working closely with the Education team on developing and publishing guidance on student FtP. In this quarter we have undertaken the first phase of engagement including analysis of stakeholder feedback, drafting a revised version of the guidance and development of several case studies that will accompany the guidance. In the next phase we will carry out further stakeholder engagement to gather stakeholders’ views on the proposed guidance. We are still on schedule to launch new student FtP guidance in early 2020.
## Implementing our approach to regulating registered pharmacies

**Strategic aim:** The pharmacy team have the necessary knowledge, attitudes and behaviours

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### In 2019/20 we will:

- Implement the updated principles and approach to how we regulate registered pharmacies
- Publish our inspection reports and examples of notable practice in the knowledge hub
- Enhance our capability to assess the increasing range of clinical and technology supported pharmacy services
- Implement a pro-active programme of awareness raising and communication to the sector and the public on key issues affecting patient safety
- Make full use of our enforcement options in line with our enforcement policy

### What does success look like?

- Risks to patient safety are being effectively minimised and the quality of pharmacy practice is continually improving
- Inspection reports are easily accessible and useful to the public and examples of notable practice are being used by the sector to improve quality in pharmacy practice
- We can effectively assess the quality of the full range of clinical pharmacy practice and types of models operating
- We are proactively providing the public with clear information to help inform their health and well-being choices when using pharmacy services
- Different types of enforcement action are taken when appropriate

### Key links and assumptions

- Publication of inspection reports by the revised end of the Summer 2019 is dependent upon the build of the reporting web site with supporting infrastructure (updated for Q1 reporting)
- Publication of inspection reports and implementation of the refined approach is dependent upon the availability of sufficient resources to develop, project manage and operationalise the key workstreams

### Main risks

- The operational preparedness of the inspectorate and the development of the IT infrastructure to support the publication of inspection reports is the key building block to the refined inspection approach within the current timescales
- Publication of inspection reports exposes us to greater external scrutiny and potential legal challenge of judgements made
Outline timetable:

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<tr>
<td>• Implement refinements to our approach to inspection which will include different inspection types, unannounced inspections and changes to the overall outcome&lt;br&gt;• Using a range of data, information and intelligence to inform our risk-based model and decisions on inspection activities&lt;br&gt;• Publication and promotion of first batch of inspection reports and notable practice case studies&lt;br&gt;• Baseline assessment of clinical practice complete&lt;br&gt;• Complete methodology for themed inspection reports for piloting&lt;br&gt;• Promote and explain the updated approach to how we regulate pharmacies to all stakeholders through a range of new resources and channels&lt;br&gt;• Develop and initiate an online awareness-raising campaign for patients and the public on obtaining medicines safely online</td>
<td>• Updating and finalisation of range of inspection methodologies for assessing the full range of clinical pharmacy practice and online/distance selling, hub and spoke types of service models&lt;br&gt;• Pilot themed inspection methodology&lt;br&gt;• Skills and knowledge framework for inspectorate updated with training programme and options for enhanced clinical and technology skills where required completed&lt;br&gt;• Publish a new online guide for patients and the public on what they can expect from pharmacists, pharmacy technicians and pharmacies&lt;br&gt;• Ongoing activities to promote the online awareness-raising campaign for patients and the public on obtaining medicines safely online&lt;br&gt;• Publication and promotion of first batch of inspection reports and notable practice case studies</td>
<td>• Start of work to develop a longer-term specialist and flexible clinical and technical resource model to support our work&lt;br&gt;• Publication of the first pilot themed inspection report. Preparatory work for second themed inspection&lt;br&gt;• Promote the publication of the first pilot themed inspection report, highlighting learnings and areas of good practice&lt;br&gt;• Identify further opportunities to promote the guide on what the public can expect from pharmacies and pharmacy professionals</td>
<td>• Specialist clinical and technical affiliate resource model fully operational&lt;br&gt;• Publication of second themed inspection&lt;br&gt;• Seek further opportunities to share notable practice examples across the sector, including through Regulate and through other organisations’ channels&lt;br&gt;• Promote the publication of the second themed inspection report, highlighting learnings and areas of good practice&lt;br&gt;• Complete methodology for themed inspection reports for piloting</td>
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</table>
Commentary:

The overall RAG status is green which is the same as the previous quarter and reflects the overall positive progress made in this priority area.

Implement the updated principles and approach to how we regulate pharmacies
There has been good progress with the scheduled activities under this key area this quarter. At the beginning of April 2019, we started to inspect registered pharmacies under the refined approach approved by Council in December 2019 in line with expected timelines. This included changes to the outcomes of an inspection, unannounced inspections, a more risk informed routine inspection programme and intelligence led inspections as examples.

Publication of inspection reports and examples of notable practice in the knowledge hub
Work has progressed well this quarter with the development of the publication site for inspection reports and notable practice and we remain on track with the rescheduled timeline to start publishing all reports in the Summer of 2019. This was to ensure development of the publication was not rushed, enough inspection reports and examples of noticeable practice were published, and that there was time for engagement with stakeholders around publication and learning from inspection research in advance of go-live. In addition, during this we have continued with our programme to upskill our inspectors to ensure that the summary reports are written in easily accessible plain English for the public. We have also continued to engage directly with key stakeholders across pharmacy to increase awareness and understanding of the principles behind publication and what that will mean in reality in relation to inspection reports and improvement action plans. We have not completed the scheduled activity of finishing the methodology for themed inspection reports for piloting this quarter. This is because it was re-scheduled due to the significant work involved in implementing the updated changes to our inspection approach and working towards publishing inspection reports. Whilst work started, this activity has been re-scheduled for the last quarter of this year to pilot a themed inspection approach.

Enhance our capability to assess the increasing range of clinical and technology supported pharmacy services
In this quarter, we completed the scheduled activity of the outline baseline assessment of clinical practice in all pharmacy settings. This is informing the work which has started to develop a flexible specialist clinical and technical resource to draw upon when required.

Implement a pro-active programme of awareness raising and communication to the sector and the public on key issues affecting patient safety
During this quarter, our scheduled activities under this priority area mostly related to obtaining medicines on-line. We updated guidance on providing pharmacy services at a distance, including on the internet and received extensive coverage in national and trade media, including the BBC, Daily Mail, Guardian, Pulse and the Pharmaceutical Journal. We also contacted all pharmacy professionals and pharmacy owners directly via email to make them aware of the new guidance. Pharmacy owners with pharmacies displaying the internet logo received a tailored email asking them to review the guidance and consider the steps they will take to follow it within their online pharmacies. This will be followed up through inspections. We also updated our advice for patients and the public on how to buy medicines safely online, available via our website, and have asked organisations representing patients and the public to share this advice through their networks. We also arranged a meeting with other health regulators and other relevant health organisations in May
to explore opportunities to develop a joint resource for patients and the public about how to use online primary care services safely. A joint resource is now being drafted.

To promote and explain the updated approach to how we regulate pharmacies to all key stakeholders through a range of new resources and channels, we have continued to engage directly with pharmacy owners, pharmacy professionals and representative organisations across pharmacy ahead of the introduction of the publication of inspection reports and the launch of the report looking at learnings from pharmacy inspections over the last five years, the PLEA seminar being an example. Another key focus during this quarter has been supporting the development of the new inspection publication website, including developing the text for the website and working with the website developers to make sure the website is accessible to all users.

**Making full use of our enforcement powers in line with our enforcement policy**

Whilst there were not specific scheduled activities under this priority area this quarter, during this quarter we have started using our new statutory powers in several cases in line with the enforcement policy which was published in March 2019.
<table>
<thead>
<tr>
<th>Setting and upholding standards</th>
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<tr>
<td><strong>Strategic aim:</strong> The pharmacy team have the necessary knowledge, attitudes and behaviours</td>
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</table>

**In 2019/20 we will:**
- Agree a revised set of initial education and training standards for pharmacists ready for implementation
- Implement revised education and training standards for pharmacist independent prescribers and consult on guidance for safe and effective prescribing
- Agree policy for the education and training of support staff in the pharmacy team
- Commence a review of how we accredit education and training providers
- Invest in the development of new standards for superintendents, chief pharmacists and responsible pharmacists, subject to legislative change
- Implement the final part of our revalidation policy with registrants providing reflective accounts and peer review submissions
- Commence accreditation of new education and training courses for pharmacy technicians based on revised standards

**What does success look like?**
- Initial Education and Training (IET) standards for pharmacists drive greater clinical and patient-centred education and training
- Education and Training (ET) standards for pharmacist independent prescribers equip pharmacist independent prescribers with the necessary skills and knowledge to prescribe safely
- Policy on the ET of support staff provides public assurance and reflects the current pharmacy environment and changing roles of support staff
- Standards set clear expectations and accountabilities in the interest of public safety
- Registrants demonstrate their continuing learning and development in the interests of patients and other service users through revalidation for pharmacy professionals

**Key links and assumptions**
- Key stakeholders will engage with our proposals for changes to pharmacist initial education and training
- Stakeholders agree with our proposals for changes to pharmacist initial education and training because they fit well with changes in the profession
- Legislative change will be agreed and Rebalancing will start in 2019 (added for Q1 reporting)

**Main risks**
- Factors beyond our control (changes to the funding of pre-registration training/changes to the funding of high education) make it difficult to implement the changes we are proposing to pharmacist initial education and training
- Key stakeholders (schools of pharmacy/funding bodies) do not engage with our proposals and they cannot be implemented
Outline timetable

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<tr>
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<tr>
<td>• Analysis of consultation responses</td>
<td>• Discuss findings and next steps with Council</td>
<td>• Agree standards and next steps</td>
<td>• Implement proposals for revised accreditation methodology for education and training providers</td>
</tr>
<tr>
<td>• Conclude consultation on initial education and training standards for pharmacists</td>
<td>• Promote supporting resources for peer discussion and reflective accounts to pharmacy professionals</td>
<td>• Finalise, publish and promote updated standards for the initial education and training of pharmacists</td>
<td>• Begin to implement updated standards for the initial education and training of pharmacists</td>
</tr>
<tr>
<td>• Consult and engage on our policy on the education and training of support staff</td>
<td>• Publish final guidance on prescribing</td>
<td>• Develop proposals for revised accreditation methodology for education and training providers</td>
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</tr>
<tr>
<td>• Consult and engage on prescribing guidance</td>
<td>• Scope our review of accreditation of education and training providers</td>
<td>• Confirm policy for the education and training of support staff</td>
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<tr>
<td>• Promote supporting resources for peer discussion and reflective accounts to pharmacy professionals</td>
<td>• Review of revalidation functionality</td>
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<tr>
<td>• Confirm policy for the education and training of support staff</td>
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To Note: Timescales relating to superintendents, chief pharmacists and responsible pharmacists to be added once legislative position confirmed.
Commentary:

The overall RAG status is green for the key pieces of work associated with the delivery of this priority area which remain on schedule.

Agree a revised set of initial education and training standards for pharmacists ready for implementation
Progress on the timetabled activity remains positive, although will be kept under review moving forwards. We closed the consultation on the initial education and training of pharmacists at the beginning of April. Following the development of the coding framework, in April, we coded consultation responses and quality assured coding work until the second half of May. The rest of Q1 has been spent writing the consultation analysis report, which will be presented to Council in September 2019.

Following the consultation, we assessed that a second phase of stakeholder engagement was necessary to identify how standards and learning outcomes for the five years of initial education and training could be delivered.

Implement revised education and training standards for pharmacist independent prescribers and consult on guidance for safe and effective prescribing
This activity is on schedule. The consultation and stakeholder engagement event were concluded at the end of June and work has begun on the analysis report which will be finished mid/late August and go to Council in September 2019.

Agree policy for the education and training of support staff in the pharmacy team
With regard to the two timetabled activities for this quarter, one is green and the other amber mainly due to rescheduling required. Focussed engagement on a set of revised and updated requirements is well underway as per the 2018/19 Q4 update but the timescale has been extended to ensure that engagement activities do not clash with the all-registrant survey. We have completed engagement activities with three groups of stakeholders on the revised requirements, including employers, course providers and representative bodies. Following the initial round of engagement events, we modified our position on exemptions for pharmacy students and are engaging on this basis. The public facing survey on the requirements to gather wider feedback has been delayed and is to close on 20 August to avoid clashing with the all-registrant survey. We will look to confirm our policy for the education and training following consultation, engagement and analysis activities; this has been rescheduled to Q3.

Commence a review of how we accredit education and training providers
There are not timetabled activities under this workstream this quarter.

Invest in the development of new standards for superintendents, chief pharmacists and responsible pharmacists, subject to legislative change
Whilst we are still awaiting confirmation from the Department of Health and Social Care regarding rebalancing, we have started initial planning on the possible approaches to undertaking this work, engaging with stakeholders and reviewing the timetable for delivery.
Implement the final part of our revalidation policy with registrants providing reflective accounts and peer review submissions
Good progress has been made on this activity with cross-team working to provide additional support/resources for both registrants and reviewers for example, provision of FAQs; updating the revalidation framework and providing examples of good practice for reviewers on how to provide feedback. Reviewing the peer reviews and reflective statements started slightly later than planned but have progressed well. Training of reviewers took place on time and reviewing started in June 2019.

Commence accreditation of new education and training courses for pharmacy technicians based on revised standards
There has been ongoing liaison with providers as they develop new courses.
### Operating as a professional, lean organisation

**Strategic aim:** Pharmacy regulation is efficient and effective

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#### In 2019/20 we will:

- Launch our 10-year vision and develop a supporting strategic plan
- Develop a medium to long-term financial strategy
- Move applications for pharmacist pre-registration training, the registration assessment and pharmacy technician initial registration on-line
- Continue the migration of our IT infrastructure and services to the cloud
- Develop a medium to long-term strategy for the development of our key business systems aligned to organisational priorities
- Develop an updated comprehensive Equality, Diversity and Inclusion strategy with a focus on our regulatory functions
- Draft, plan and begin implementation of a 3-5-year organisational development strategy
- Initiate a review of our current and future accommodation requirements

#### What does success look like?

- We are clear where we are aiming to be in 10 years’ time and it is guiding our business planning
- We have a longer-term strategy which enables us to plan for and deliver a sustainable financial position that supports the delivery of our vision
- Pre-registration pharmacists and pharmacy technicians can complete their pre-registration and registration assessment applications, and initial pharmacy technician registration on-line simply and efficiently
- Reduced cost of ownership for IT services
- We have a clearly defined plan for our business systems in line with our priorities
- Our policies and practices reflect and support the diverse registrant and organisational population, enhancing their experience
- We are clear how our organisation needs to work in order to deliver our priorities
- Our accommodation strategy enables us to demonstrate value for money alongside a commitment to reducing our carbon footprint

#### Key links and assumptions

- This annual plan represents a transition period as we continue to set our longer-term goals and develop our plans to achieve these
- We continue to keep our plans under review to respond to significant challenges facing society in general and pharmacy in particular
- Relevant strategies are developed aligned to our future organisational priorities

#### Main risks

- We are seen as a regulator which is accessible to our stakeholders across the three nation states
- Lack of commitment and engagement to a longer-term vision, strategic plan and supporting planning framework means our strategic, operational and financial planning are unaligned
- Capacity and resources to implement change across the different pieces of work that make up this strategic priority
Outline timetable:

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<tbody>
<tr>
<td>• Complete engagement on draft Vision and commence development of supporting 10-year plans</td>
<td>• Approval and launch of Vision</td>
<td>• 5-year Strategic plan (informed by 10-year plans) to Council for approval</td>
<td>• Annual plan and budget for 2020/21 to Council for approval</td>
</tr>
<tr>
<td>• Complete implementation of online pre-registration pharmacist applications</td>
<td>• Continued development of supporting 10-year plans</td>
<td>• ‘SharePoint’ online for Info point go live</td>
<td>• Continue development and testing for online applications for the registration assessment</td>
</tr>
<tr>
<td>• ‘One drive’ and ‘Intune’ go live (replacing H drive and Maas 360))</td>
<td>• Development and initial testing of online pharmacy technician initial registration</td>
<td>• Implement, monitor and review the medium to long-term strategy for the development of our key business systems aligned to our organisational priorities</td>
<td>• Implement, monitor and review the medium to long-term strategy for the development of our key business systems aligned to our organisational priorities</td>
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<tr>
<td>• Skype upgrade</td>
<td>• Skype on line for video and messaging go live</td>
<td>• Assess the effectiveness of governance arrangements for the development of our key business systems</td>
<td>• Final budget and financial strategy proposal for approval</td>
</tr>
<tr>
<td>• Implement governance arrangements for the development of our key business systems</td>
<td>• Asses the effectiveness of governance arrangements for the development of our key business systems</td>
<td>• Development of medium to long-term strategy for the development of our key business systems aligned to organisational priorities</td>
<td>• Phased implementation of the new operating model and organisation design commences</td>
</tr>
<tr>
<td>• Develop a medium to long-term strategy for the development of our key business systems aligned to organisational priorities</td>
<td>• Develop a medium to long-term strategy for the development of our key business systems aligned to organisational priorities</td>
<td>• Final testing and go-live of online pharmacy technician initial registration</td>
<td>• Develop models to understand our cost base</td>
</tr>
<tr>
<td>• Develop models to understand our cost base</td>
<td>• Cost base established using model</td>
<td>• Initial development for online applications for the registration assessment</td>
<td>• Implementation of cloud-based finance system</td>
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<tr>
<td>• Implementation of cloud-based finance system</td>
<td>• Go-live of cloud-based finance system</td>
<td>• Draft budget and financial strategy proposal delivered to council</td>
<td>• Development of medium to long term financial strategy to support the 10-year Vision (including Investment, fees and reserves strategy)</td>
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<tr>
<td></td>
<td>• Development of medium to long term financial strategy to support the 10-year Vision (including Investment, fees and reserves strategy)</td>
<td>• Produce EDI action plan and key metrics</td>
<td>• Publish EDI strategy</td>
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<tr>
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<td>• Publish EDI strategy</td>
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<td>• Establish the new operating model and organisation design</td>
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• Progress of migration to cloud work dependent upon successful renewal process for IT infrastructure managed services contract
• Interdependencies between multiple pieces of work
• There is a reduction in performance during the implementation of the new organisation design
• The EDI strategy is not embedded in our regulatory and policy priorities
• Review and update allocation model for assessing costs for the different registrant groups
• Conduct stakeholder engagement on key themes for the EDI strategy
• Identify potential options for reducing costs in current accommodation arrangements include the exploration of income generation opportunities

• Develop proposals for medium to long-term accommodation requirements

Commentary:

The overall RAG status is amber as the EDI strategy work remains behind schedule although action is being taken to address this as outlined in the commentary section below.

Launch our 10-year vision and develop a supporting strategic plan
In relation to the timetabled activity under this priority workstream progress has been positive although activities have continued into Q2. Engagement on the draft 10-year Vision has been taking place with a wide-range of key stakeholders following Council’s agreement to do so in March 2019. So far and overall there has been a positive response to the draft Vision and feedback outlining key themes will be presented to Council in September. In addition to this, work has begun on our 10-year planning.

Develop a medium to long term financial strategy
Several strands of a financial strategy are being progressed, albeit work on the activities in the outline timetable require further work. Work to update the current cost allocation model is currently underway and is due to be presented to the September Finance and Planning Committee. Both investment and fee strategies are also being progressed.

Move applications for pharmacist pre-registration training, the registration assessment and pharmacy technician initial registration on-line
Work in relation to this timetabled activity has been positive. May 2019 saw the release of the online application for pre-registration training for the 2019/20 training year. Revalidation reviews commenced in June 2019 with the first batch of feedback reports being released to registrants in July 2019 (see also ‘setting consistent standards’ section). An external facing API (Application Programming Interface) is being developed and details will be provided to one of the professional bodies.
Continue the migration of our IT infrastructure and services to the cloud
Progress on these timetabled activities is mixed with two at amber and one green.

- **OneDrive and Intune**
  The Intune system is now live and the Maas 360 system has been decommissioned.
  OneDrive, which will replace the H drive has now gone live for the pilot group. The full roll out has been delayed due to availability of resource by the supplier.

- **Skype Upgrade**
  There has been a delay to the Skype upgrade which has been due to a change in approach caused by emerging technical issues with the latest release of Skype. The revised upgrade approach has been designed and will be implemented in July.

- **Cloud based finance system**
  The cloud-based finance system is in the final test phase prior to live release at the end of Q2 2019/20

To note, the Infrastructure managed services contract has been extended until February 2021 which addresses one of our key links and assumptions.

**Develop a medium to long-term strategy for the development of our key business systems aligned to organisational priorities**
Work on this timetabled activity has progressed well as we have started developing a roadmap showing a time phased development plan with interproject dependencies. This work will continue in July and August and input from all Heads of Function and Directors will be gathered. The Systems Development Steering Group has now been formed. Initial meetings have been held and the Terms of Reference has been agreed.

**Develop an updated comprehensive Equality, Diversity and Inclusion strategy with a focus on our regulatory functions**
There has been some slippage in the EDI strategy development work. However, we are prioritising work in this area now. Internal staff focus groups are scheduled to take place; the EDI manager is attending staff management and directorate meetings to update and seek input from all staff groups and a draft framework has been completed, together with a methodology and communication plan. Discussions have taken place with internal colleagues who have offered to support this initiative and to ensure that cross-working takes places to achieve symmetry between the newly emerging FtP strategy and the overall 5-year strategic plan.

**Draft, plan and begin implementation of a 3-5-year organisational development strategy**

**Focuses:**
- **Pay Review 2019/2020** completed on time for new salaries to take effect from 1 June 2019.
Culture

- **PDR Completion**: Following the delivery of workshops for all people managers in Q4: 2018/2019; 88% of colleagues from across the GPhC completed their year-end objectives which was an excellent result following the roll out of this new on-line PDR process between February & March 2019. We are unable to provide a % from last year as a comparison as the process was manual then.

- Work is now directed towards the completion of setting new objectives for 2019/2020 in readiness for mid-year reviews. The focus for this time of the year is on embedding the behaviour framework.

- **HRIS System**: Simply Personnel: this system holds all of our employee data for the GPhC, we have been advised that the system has reached an “end of life stage” by the provider. HR and IT are working together to understand the implications from a management and software perspective, which includes reviewing other systems with the procurement team as a matter of urgency.

Initial re-organisation policy drafted and approved by the senior leadership group. Additional paper in progress for the remuneration committee on 3 October 2019.

**Initiate a review of our current and future accommodation requirements**

There has been progress on this activity although this is an emerging piece of work. Work on the accommodation arrangements is currently focussed on minimising the impact of the rent review which will be effective from May 2019 once the new rental rate has been agreed (within the pre-defined limits set out in the existing lease). Work on longer-term accommodation needs will be progressed later in the year.
Performance Monitoring Report: end June 2019
1. Customer services

1.1 Registrations

<table>
<thead>
<tr>
<th>Route to Register</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>2,334</td>
</tr>
<tr>
<td>UK</td>
<td>54</td>
<td>2,257</td>
</tr>
<tr>
<td>EEA</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Non-EU/EEA</td>
<td>5</td>
<td>48</td>
</tr>
<tr>
<td>Pharmacy technicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>208</td>
<td>336</td>
</tr>
<tr>
<td>UK</td>
<td>208</td>
<td>333</td>
</tr>
<tr>
<td>EEA</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Non-EU/EEA</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| Registered pharmacies | 73 | 81 | 70 | 78 | 70 |

Includes new joiners and restorations up to 30th June 2019

New registration activity is generally light over this quarter as there are no key reasons for entry such as immediately following an assessment or the end of the academic timetable (for pharmacy technicians).

1.2 Registration Totals

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Budgeted</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacists</td>
<td>56,221</td>
<td>56,403</td>
<td>-182</td>
</tr>
<tr>
<td>Pharmacy technicians</td>
<td>23,526</td>
<td>23,583</td>
<td>-57</td>
</tr>
<tr>
<td>Registered pharmacies</td>
<td>14,309</td>
<td>14,323</td>
<td>-14</td>
</tr>
</tbody>
</table>

Register totals as at 30th June 2019
The number of pharmacists, pharmacy technicians and registered premises are broadly in line with budget forecasts, although each shows a small reduction.

### 1.3 Median application processing times for pharmacy professionals

<table>
<thead>
<tr>
<th>Median application processing times for pharmacists (working days)</th>
<th>Median application processing times for pharmacy technicians (working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application receipt to approval</td>
<td>Application receipt to approval</td>
</tr>
<tr>
<td>Application receipt to entry</td>
<td>Application receipt to entry</td>
</tr>
</tbody>
</table>

- 0.0
- 0.0
- 4.0
- 9.0

*Medians calculated for applications during the period 1st April to 30 June 2019.*

The application receipt to approval is the time from the date the application was received to the date of the decision to approve the application.

The application receipt to entry is the time from the date the application was received to the date it was entered onto our register as we currently have two entry points to the register a month.

Pharmacist application turnover for the period remains consistent following the introduction of the new Registrant Online Services process for pharmacists where we measure from the date the application is complete.

Pharmacy technician applications are currently paper-based and require manual processing upon receipt. Pharmacy technician applications are due to go online later this year and we expect to see quicker decisions as a result.
1.4 Contact Centre

<table>
<thead>
<tr>
<th>Phone</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Calls made to GPhC</td>
<td>24,005</td>
<td>28,368</td>
</tr>
<tr>
<td>Calls answered within 20 seconds (KPI &gt; 80%)</td>
<td>23.5%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Calls abandoned (KPI &lt; 5%)</td>
<td>38.0%</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

Correspondence

<table>
<thead>
<tr>
<th>Correspondence</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Emails actioned within 2 days (KPI &gt; 90%)</td>
<td>51.9%</td>
<td>71.1%</td>
</tr>
</tbody>
</table>

The KPI’s for telephone abandonment rate and email responses were achieved.

73.2% of telephone calls were answered within 20 seconds. A further breakdown below shows the percentage of calls answered where callers had to wait for longer (more than a minute);

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>1-2 mins</th>
<th>2-5 mins</th>
<th>5-10 mins</th>
<th>&gt; 10 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2018-19</td>
<td>4.1%</td>
<td>4.5%</td>
<td>2.5%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Q1 2019-20</td>
<td>7.1%</td>
<td>8.3%</td>
<td>3.0%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

This was a busy quarter for the contact centre, with queries being mainly generated from the following;
- Renewal and revalidation queries, as we progress through the yearly renewal cycles, and registrants renew and prepare their revalidation records for the first time on the new basis.
- Revalidation review and feedback, as we begin to review records on the new basis.
- An increasing number of queries relating to peer review and reflective accounts, with the first cohort due to submit these records soon.
- Pre-registration queries for new applicants, as we receive and process applications from those joining the 2019-20 scheme.
- The new online services facility for new pre-registration applications was launched in April. No major issues reported.
- Queries relating to the registration assessment – adjustment requests, processing of applications, allocation of assessment venues, withdrawals and potential “on the day” queries.
## 1.5 Revalidation for pharmacy professionals

<table>
<thead>
<tr>
<th>Revalidation activities</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td><strong>Renewal cohort</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbers expected to renew</td>
<td>45,495</td>
<td>4,324</td>
</tr>
<tr>
<td>Numbers of renewals</td>
<td>43,270</td>
<td>4,013</td>
</tr>
<tr>
<td>% renewals (all expected to renew)</td>
<td>95.1%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Number of voluntary removals</td>
<td>1,523</td>
<td>118</td>
</tr>
<tr>
<td>% voluntary removal (all expected to renew)</td>
<td>3.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Number of lapsed registrants</td>
<td>581</td>
<td>47</td>
</tr>
<tr>
<td>% lapsed registered (all expected to renew)</td>
<td>1.3%</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Complete revalidation submissions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of revalidation submissions</td>
<td>43,155</td>
<td>3,967</td>
</tr>
<tr>
<td>% revalidation submissions (all expected to renew)</td>
<td>94.9%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Number of revalidation and renewal</td>
<td>43,031</td>
<td>3,946</td>
</tr>
<tr>
<td>% revalidation and renewal (all expected to renew)</td>
<td>94.6%</td>
<td>91.3%</td>
</tr>
<tr>
<td>% revalidation and renewal (all renewals)</td>
<td>99.4%</td>
<td>98.3%</td>
</tr>
<tr>
<td><strong>Remediation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number entered into revalidation remediation</td>
<td>2,696</td>
<td>458</td>
</tr>
<tr>
<td>% entered into revalidation remediation (all renewals)</td>
<td>6.2%</td>
<td>11.4%</td>
</tr>
<tr>
<td><strong>Removal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number notified of intent to remove</td>
<td>1,805</td>
<td>189</td>
</tr>
<tr>
<td>Number notified of removal</td>
<td>171</td>
<td>19</td>
</tr>
<tr>
<td>Number administratively removed</td>
<td>67</td>
<td>4*</td>
</tr>
<tr>
<td><strong>Appeals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of appeals received</td>
<td>Process not started yet – no data</td>
<td>Process not started yet – no data</td>
</tr>
<tr>
<td>Number of appeals upheld</td>
<td>Process not started yet – no data</td>
<td>Process not started yet – no data</td>
</tr>
</tbody>
</table>

*Revalidation activity totals as at 15 August 2019 – Please note that all other data for Q3 and Q4 2018/19 figures have not been updated and are correct as at 17 May 2019*
The revalidation process intends to provide assurance to members of the public that the people on our register are reflecting on their practice. It provides an annual opportunity for our registrants to demonstrate professional learning and reflection and can act as a prompt for some to consider their registration.

This is the third performance monitoring report to contain information on outcomes for revalidation for pharmacy professionals following its launch in April 2018. The data was collected on 15 August 2019. The revalidation process takes time to complete and this snapshot of data is only representative of the submission of revalidation records in Q1 2019/20. The data for quarters 3 and 4 in 2018/19 is a snapshot at 17 May 2019. Please note that the numbers in the cohort expected to renew can change slightly due to registrants restoring to the register and maintaining the renewal date based on the anniversary of their initial date of registration.

Owing to the length of time it takes to provide registrants with opportunities to remediate and provide representations, it takes time to report on the number of administrative removals from the renewal cohorts. For the Q4 2018/19 cohort there have now been 4 administrative removals (as at 15 August 2019). For the Q1 2019/20 renewal cohort, there have been 2 administrative removals so far.

We report our data based on the expected renewal date for registrants, but because of extensions granted to registrants we may still make changes to the data for previous cohorts in Q3 and Q4 and receive appeals for decisions related to registrants expected to renew in this quarter.

During Q1, 19,969 registrants were required to renew their registration and submit revalidation records. 97.6% of registrants in this cohort successfully renewed their registration. 99.4% of registrants who renewed also successfully submitted complete revalidation submissions.

We have processed 175 requests for voluntary removals during this quarter which is a reduction by a third compared to the proportions in the last two quarters at around 1% compared to 3% of all registrants expected to renew. We have also had 71 registrants (0.4%) take no action in response to reminders of their renewal deadline and so their registration has lapsed.

We have examined the reasons for leaving from the voluntary removal applications as part of evaluation activities for revalidation. In Q1, the majority (a third) of registrants did not provide a reason for leaving. For the registrants that did provide a reason for leaving, these related to moving abroad (23.3%), profession change (18.8%), other (8.3%), career break (5.5%), maternity/paternity/parental leave (5.0%), personal (5.0%), health (2.8%), retirement (0.6%) and revalidation (0.6%). Only one application cited Revalidation as a reason for leaving. We do not know if revalidation was a factor for any registrants who did not give a reason for leaving or who allowed their registration to lapse.

In this quarter, 761 registrants (3.9%) have been placed into remediation because they either submitted partial or no revalidation records, which is a lower proportion of 3.9% compared to 11.4% in the last quarter. 382 of these registrants went on to submit complete records and so only 379 letters stating an intent to remove registration were sent (1.9%). We have now seen most of the remaining registrants take appropriate action to submit records. Only 3 letters of notice of removal have been sent which is a continuing decrease from previous quarters.
2. **Fitness to Practise (FtP)**

2.1 **Fitness to Practise performance standards**

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th></th>
<th></th>
<th>2019/20</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td>All concerns received during this period</td>
<td>No.</td>
<td>681</td>
<td>635</td>
<td>702</td>
<td>656</td>
</tr>
<tr>
<td>All cases triaged during this period</td>
<td>No.</td>
<td>704</td>
<td>626</td>
<td>629</td>
<td>700</td>
</tr>
<tr>
<td>Of which cases triaged within 5 working days</td>
<td>No</td>
<td>599</td>
<td>546</td>
<td>489</td>
<td>318</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>85.1%</td>
<td>87.2%</td>
<td>77.7%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Of which cases were closed at triage</td>
<td>No</td>
<td>254</td>
<td>209</td>
<td>240</td>
<td>329</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>36.1%</td>
<td>33.4%</td>
<td>38.2%</td>
<td>47.0%</td>
</tr>
</tbody>
</table>

We received 661 concerns in Q1 of 2019/20 compared to 681 in Q1 of 2018/19. The average number of concerns received each quarter in 2018/19 was 669. It appears that the rate of increase in the number of concerns we receive has slowed and may be beginning to plateau.

There have been considerable improvements to the time taken to triage concerns in Q1. The percentage of cases triaged in five-days (64%) targets has increased. Our concerns team is currently fully staffed with no new starters this quarter. Following the introduction of additional oversight in Q3 2018/19 the team are better able to anticipate initial inquiries that will be requested and have been able to increase the number of concerns processed within targets.

The number of concerns closed at triage has increased in Q1 of 2019/20 and is around 49% of all concerns received. Over the last three quarters, there has been a trend of increasing numbers of concerns closed at triage.

The increase in the number of concerns closed at triage results from several factors including:

- greater use of regulatory levers such as the passing of soft intelligence to Inspectorate colleagues and other agencies
- senior support through oversight allowing concerns to be closed at triage, which previously would have been referred for investigation and been closed subsequently during that process
- productivity in the team has improved because the team is now fully staffed.
We continue to assure the quality of triage routing decisions through a combination of sign-off at certain decision stages, team supervision, regular management quality assurance checks and retrospective audit and compliance checking as part of our quality programme.

In addition to our assurance checks we also monitor the number of corporate complaints received where the complainant objects to the concern being closed at triage and where a decision is then made to revise the triage decision and refer the matter for investigation.

2.1 Fitness to Practise performance standards (cont.)

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>All stream 1 cases closed pre-IC</td>
<td>No.</td>
<td>252</td>
</tr>
<tr>
<td>Of which closed within 13 weeks (3 months)</td>
<td>No.</td>
<td>210</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>83.3%</td>
</tr>
<tr>
<td>All stream 2 cases closed pre-IC or referred to the IC</td>
<td>No.</td>
<td>154</td>
</tr>
<tr>
<td>Of which closed or referred within 44 weeks (10 months)</td>
<td>No.</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>73.4%</td>
</tr>
<tr>
<td>All cases closed or referred at IC</td>
<td>No.</td>
<td>28</td>
</tr>
<tr>
<td>Of which reach IC within 52 weeks (12 months)</td>
<td>No.</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>46.4%</td>
</tr>
<tr>
<td>All FTP committee cases closed</td>
<td>No.</td>
<td>18</td>
</tr>
<tr>
<td>Of which closed within 104 weeks (24 months)</td>
<td>No.</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

The total number of cases closed or referred in Q1 of 2019/20 is 427, which is slightly lower than the average number of cases closed or referred each quarter in 2018/19 (430).
The number of cases closed at stream 1 (261) has increased in Q1 of 2019/20 compared to the average for each quarter in 2018/19 (237). The number of cases closed at stream 1 within target (13 weeks) was 210, which is an increase or equal to all quarters in 2018/19 but a slightly lower percentage (81%) than the average for each quarter 2018/19 (83%).

The number of stream 2 cases closed or referred (129) has decreased in Q1 of 2019/20 compared to the average for each quarter of 2018/19 (148). This is against the backdrop of a fall in the overall stream 2 caseload (see table 2.2). The number of stream 2 cases closed or referred within target (44 weeks) was 79, which is a reduction compared to all quarters in 2018/19 and a lower percentage (61%) than the average for each quarter in 2018/19 (72%). Staff turnover, absences and vacancies during the quarter resulted in unavoidable case re-allocations which in turn have slowed down case progression. At the same time we are seeing fewer cases referred to stream 2 that are likely to be resolved quickly because senior oversight at triage has helped identify more appropriate regulatory routes outside FtP for these cases. This has contributed to the ageing profile of stream 2 cases.

The number of cases closed or referred by the IC (22) is up compared to the previous quarter but has decreased compared to the average for each quarter of 2018/19 (24). The number of cases closed or referred at the IC within target (52 weeks) was 11, which is higher than Q4 of 2018/19 but lower than Q1-3 and a lower percentage (50%) than the average for each quarter in 2018/19 (54%).

The number of cases closed by the FtPC (15) is lower compared to the average for each quarter of 2018/19 (19). The number of cases closed by the FtPC within target (104 weeks) was 6, which is marginally lower than in all but one quarter in 2018/19 but a higher percentage (40%) than the average for each quarter in 2018/19 (33%).
2.2 Caseload age profile

<table>
<thead>
<tr>
<th>Age profile</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Under 26 weeks (Under 6 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>453</td>
<td>498</td>
</tr>
<tr>
<td>%</td>
<td>60.2%</td>
<td>61.6%</td>
</tr>
<tr>
<td>26 - 52 weeks (6-12 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>150</td>
<td>148</td>
</tr>
<tr>
<td>%</td>
<td>19.9%</td>
<td>18.3%</td>
</tr>
<tr>
<td>52 - 65 weeks (12-14 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>%</td>
<td>5.3%</td>
<td>6.2%</td>
</tr>
<tr>
<td>65 weeks old and over (15 months old and over)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>109</td>
<td>113</td>
</tr>
<tr>
<td>%</td>
<td>14.5%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Total</td>
<td>752</td>
<td>809</td>
</tr>
<tr>
<td>%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The total number of cases reduced in Q1 of 2019/20 to 678, the lowest it has been for over a year. This is a decrease of 72 cases since the previous quarter and shows a trend of reduction since Q3 of 2018/19.

There were 506 cases aged under 52 weeks in Q1 of 2019/20 (75% of the total number of cases). The average proportion of the case load under 52 weeks in 2018/19 was 81%.

There were 172 cases aged over 52 weeks in Q1 of 2019/20 (25% of the total number of cases). The average proportion of the case load over 52 weeks in 2018/10 was 19%.

The number of cases aged 65 weeks or over (113) is slightly lower than in Q4 of 2018/19 but is a slightly larger proportion (17%) of the total number of cases compared to Q4 of 2018/19. This is a decrease of 2 cases and increase of around 2%. 
2.3 Cases over 52 weeks (12 months)

<table>
<thead>
<tr>
<th>Status</th>
<th>2018/19</th>
<th></th>
<th></th>
<th></th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td>On Hold</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>37</td>
<td>49</td>
<td>48</td>
<td>49</td>
<td>62</td>
</tr>
<tr>
<td>%</td>
<td>24.8%</td>
<td>30.1%</td>
<td>30.0%</td>
<td>31.8%</td>
<td>36.0%</td>
</tr>
<tr>
<td>Post-IC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>73</td>
<td>66</td>
<td>53</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>%</td>
<td>49.0%</td>
<td>40.5%</td>
<td>33.1%</td>
<td>30.5%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Pre-IC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>39</td>
<td>48</td>
<td>59</td>
<td>58</td>
<td>64</td>
</tr>
<tr>
<td>%</td>
<td>26.2%</td>
<td>29.4%</td>
<td>36.9%</td>
<td>37.7%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>149</td>
<td>163</td>
<td>160</td>
<td>154</td>
<td>172</td>
</tr>
<tr>
<td>%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The total number of cases aged over 52 weeks (172) has increased in Q1 of 2019/20 and is higher than the average for each quarter in 2018/19 (157).

The increase in the number of cases over 52 weeks is attributed to an increase in the number of cases on hold and cases pre-IC. There were 62 cases on hold in Q1 of 2019/20 compared to an average of 46 cases in each quarter of 2018/19. Most our cases on hold and aged over 52 weeks are subject to an investigation by another agency. We engage with these agencies regularly to gather case progression updates and to explore whether it is possible to run our investigations in parallel. In Q1 around a third of the cases on hold over 12 months are related to a group of linked investigation being conducted by MHRA. There was an increase in the number of pre-IC cases over 52 weeks old (64) in Q1 of 2019/20 compared to an average of 41 cases in each quarter of 2018/19.

There has been a decrease in the number of post-IC cases over 52 weeks old (46) in Q1 of 2019/20 compared to the average for each quarter in 2018/20 (60).
## 2.4 Cases over 65 weeks (15 months)

<table>
<thead>
<tr>
<th>Age profile</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>65 – 86 weeks (15-19 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>41</td>
<td>39</td>
</tr>
<tr>
<td>%</td>
<td>37.6%</td>
<td>34.5%</td>
</tr>
<tr>
<td>86 - 108 weeks (20-24 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>%</td>
<td>29.4%</td>
<td>31.9%</td>
</tr>
<tr>
<td>108 - 130 weeks (25-29 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>%</td>
<td>11.9%</td>
<td>14.2%</td>
</tr>
<tr>
<td>130 - 152 weeks (30-34 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>%</td>
<td>11.0%</td>
<td>7.1%</td>
</tr>
<tr>
<td>152 - 173 weeks (35-39 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>%</td>
<td>4.6%</td>
<td>8.9%</td>
</tr>
<tr>
<td>173 - 186 weeks (40-42 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>0.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>186 - 217 weeks (43-49 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>%</td>
<td>3.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>217 weeks old or over (50 months or more)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>0.9%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The total number of cases aged over 15 months (113) is relatively stable, although it has decreased slightly for the second quarter in the row and is marginally lower than the average for each quarter of 2019/20 (114).

The proportion of cases in each age profile category older than 130 weeks has increased in Q1 of 2019/20. In most of the age profile categories above this caused by an increase of one case. For cases aged 150 – 173 weeks there has been an increase of 5 cases.
The number of concerns closed at triage has remained elevated over the course of Q1 of 2019/20 with a peak of 137 concerns closed in May and an average of 113 concerns closed each month over the quarter.

---

1 The graph shows closures only. This excludes cases referred to IC as they are not deemed to be closed for the purposes of this graph.
The number of cases closed at stream 1 cases has continued to fluctuate over time. In Q1 of 2019/20 the number of stream 1 closures reflects the fluctuation across previous quarters. The average number of cases closed at stream 1 in Q1 of 2019/20 was 87 each month.

The number of cases closed at stream 2 has been in decline since the last month of Q4 of 2018/19. In Q1 of 2019/20 the average number of cases closed each month was 32.

There has been a slight increase in the in the average number of cases closed by the IC each month in Q1 of 2019/20 (4 per month compared to 3 per month in Q4 of 2018/19).

There has been a slight decrease in the average number of cases closed by the FtPC each month in Q1 of 2019/20 (5 per month compared to 6 per month in Q4 of 2018/19).

2.6 DBS referrals

There were two DBS referrals in Q1 of 2019/20.

2.7 Appeals

One statutory appeal was concluded by consent in April. We received a statutory appeal in May; this is listed for a hearing in November this year.

2.8 Interim Orders

The Fitness to Practise Committee considered 2 applications for interim orders during this quarter. One application was adjourned and heard later within the quarter. Two interim suspensions order were imposed. No applications were refused in the quarter. No interim orders lapsed in this period. All interim applications were heard within the deadline.
3. Inspection

3.1 Inspections undertaken

<table>
<thead>
<tr>
<th></th>
<th>Routine inspections</th>
<th>Follow up inspections</th>
<th>Visits before registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacies</td>
<td>751</td>
<td>54</td>
<td>25</td>
</tr>
</tbody>
</table>

Figures above relate to inspection activity between 1st April 2019 and 30 June 2019.

The number of routine inspections over the period decreased from 883 in Q4 to 751 in Q1, averaging 250 a month from 294 a month in Q4. This was a planned reduction due to implementing the updated approach to inspection at the start of April, including ongoing training for inspectors and an increased number of closures of fitness to practise cases at Stream 1 (see section 2.1).

3.2 Pharmacy premises not inspected

<table>
<thead>
<tr>
<th>Months since previous inspection</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>156 - 169 weeks (36-38 months)</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>706</td>
<td>21.8%</td>
</tr>
<tr>
<td>169 - 182 weeks (39-41 months)</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>728</td>
<td>22.5%</td>
</tr>
<tr>
<td>182 – 208 weeks (42-47 months)</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>1,114</td>
<td>34.4%</td>
</tr>
<tr>
<td>208 weeks or more (48 months or more)</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>694</td>
<td>21.4%</td>
</tr>
<tr>
<td>Total</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>3,242</td>
<td>100.0%</td>
</tr>
<tr>
<td>Of all registered pharmacies</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>14,334</td>
<td>22.6%</td>
</tr>
</tbody>
</table>
There has been an increase in the number of pharmacies not inspected for 36 months or more from 3,200 to 3,408, although this represents a relatively small increase overall. This results from several factors including a lower number of routine inspections undertaken in this quarter as we implemented the updated approach to inspection and fluctuations each quarter due to historical spikes in inspection activity. There was one pharmacy that had not been inspected for 60 months – this inspection has now been completed.

### Age profile of pharmacies not inspected for 48 months and over

<table>
<thead>
<tr>
<th>Weeks/Months since previous inspection</th>
<th>East</th>
<th>North</th>
<th>South</th>
<th>West</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>208 - 221 weeks (48 – 50 months)</td>
<td>No. 54</td>
<td>127</td>
<td>123</td>
<td>103</td>
<td>407</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>49.5%</td>
<td>47.7%</td>
<td>65.4%</td>
<td>65.2%</td>
</tr>
<tr>
<td>221 - 234 weeks (51 – 53 months)</td>
<td>No. 43</td>
<td>94</td>
<td>56</td>
<td>50</td>
<td>243</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>39.5%</td>
<td>35.3%</td>
<td>29.8%</td>
<td>31.6%</td>
</tr>
<tr>
<td>234 - 247 weeks (54 – 56 months)</td>
<td>No. 12</td>
<td>38</td>
<td>6</td>
<td>4</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>11.0%</td>
<td>14.3%</td>
<td>3.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>247 - 260 weeks (57 – 59 months)</td>
<td></td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>2.3%</td>
<td>1.6%</td>
<td>0.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>260 weeks or more (+60 months)</td>
<td>No. 1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.4%</td>
<td></td>
<td></td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>No. 109</td>
<td>266</td>
<td>188</td>
<td>158</td>
<td>721</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Figures correct as at 30th June 2019*

In this quarter, the number of pharmacies not inspected for over 54 months/234 weeks increased from 39 in Q4 to 60 in Q1. Under the updated approach to inspection, our inspectors prioritise visits according to indicators of risk, and they also focus on those pharmacies that have not been inspected for the longest period. The age profile will continue to fluctuate month by month due to previous historical spikes in inspection activity in geographical areas. To
help manage the variation, we continue to deploy our inspectors in a flexible way, using inspectors within regions to assist colleagues in different areas, as well as across regions.

3.4 Top 5 standards ranked as not met

<table>
<thead>
<tr>
<th>Standard no.</th>
<th>Description</th>
<th>Inspections</th>
<th>Q4 Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3</td>
<td>Medicines and medical devices are: obtained from a reputable source; safe and fit for purpose; stored securely; safeguarded from unauthorised access; supplied to the patient safely; and disposed of safely and securely</td>
<td>51</td>
<td>1</td>
</tr>
<tr>
<td>1.1</td>
<td>The risks associated with providing pharmacy services are identified and managed</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>2.1</td>
<td>There are enough staff, suitably qualified and skilled, for the safe and effective provision of the pharmacy services provided</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>3.1</td>
<td>Premises are safe, clean, properly maintained and suitable for the pharmacy services provided</td>
<td>26</td>
<td>9</td>
</tr>
<tr>
<td>1.2</td>
<td>Pharmacy services are managed and delivered safely and effectively</td>
<td>26</td>
<td>5</td>
</tr>
</tbody>
</table>

The above rankings relate to inspections carried out between 1 April 2019 and 30 June 2019, where reports are complete as at 2 August 2019.

In this quarter, the top 5 standards ranked as ‘not met’ have changed with standard 2.1, which relates to the adequacy of staffing, appearing in the top 5 for the first time in three quarters. There were 27 inspections out of a total of 751 pharmacies inspected where the standard was ‘not met’, which represents around 3.6%. Overall, the numbers are small and subject to variation, but we will continue to monitor the elevation of this standard to see if it is a continuing trend. Typically, the sorts of issues that were found were inadequate staff numbers to cope with the workload; staffing levels not being adequately considered before taking on a new service and inadequate provision to accommodate planned or unplanned absences. All of the pharmacies concerned have been required to complete an improvement action plan, which is monitored. The pharmacy will be re-inspected at six months in line with our updated approach.

Standard 4.3 remains the highest ranked standard not met. This relates to medicine and medical devices. We have previously provided Council with further details on which aspects of this broad standard were typically the main reasons for failure during previous quarters. Typical issues relate to: Monitoring of fridge temperatures; adequacy of date checking processes; inadequately labelled medicines; controlled drugs not stored securely; and, controlled drugs not safeguarded from unauthorised access.
We will ensure that we continue to raise awareness of these issues and what is required to meet our standards through generation of notable practice case studies for publication on the knowledge hub this summer, our learning from inspection report and through an article in the September edition of Regulate.

3.5 **Top 5 standards ranked as good**

<table>
<thead>
<tr>
<th>Standard no.</th>
<th>Description</th>
<th>Inspections</th>
<th>Q4 Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Staff have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training</td>
<td>114</td>
<td>1</td>
</tr>
<tr>
<td>1.2</td>
<td>The safety and quality of pharmacy services are regularly reviewed and monitored</td>
<td>104</td>
<td>2</td>
</tr>
<tr>
<td>2.4</td>
<td>There is a culture of openness, honesty and learning</td>
<td>94</td>
<td>3</td>
</tr>
<tr>
<td>2.5</td>
<td>Staff are empowered to provide feedback and raise concerns about meeting these standards and other aspects of pharmacy services</td>
<td>52</td>
<td>4</td>
</tr>
<tr>
<td>4.2</td>
<td>Pharmacy services are managed and delivered safely and effectively</td>
<td>49</td>
<td>5</td>
</tr>
</tbody>
</table>

*The above rankings relate to inspections carried out between 1 April 2019 and 30 June 2019, where reports are complete as at 2 August 2019.*

The top five ‘good’ standards have remained the same as quarter 4 with standard 2.2, which relates to the skills, qualifications and competence of staff, the most common standard ranked as ‘good’.
4. Complaints

4.1 Formal complaints by category

Figures correct as at 30th June 2019
4.1 Formal complaints by category (cont.)

The number of complaints we received increased, from 15 complaints in Q4 to 21 complaints in Q1; this represents a 40% increase in the numbers of complaints received, which is unusual in Q1 when we would normally expect to see a fall in complaint volumes. Overall complaints numbers are relatively low however, and any trends we identify can be varied with only a few extra complaints.

Most of the complaints we received related to ‘myGPhC’ and similar to last month, related to alleged functionality issues with the system; none of these were upheld. Complaints coded as ‘Other’ related to lost mail, process concerns and alleged wrong advice.

Of all complaints received this quarter, 3 were upheld and 2 were partially upheld. The complaints upheld related to: an inspector raising concerns which were subsequently withdrawn; a delay in processing a refund after removal; and, a delay in HR feedback following an interview. The two complaints that were partially upheld related to: reimbursement for one day of counsel hearing fee and registrant travel costs - this is on hold pending the PRC providing receipts; and, incorrect information provided by the Customer Services Team in relation to a Voluntary Removal and related pro-rata refund.
5. **Education**

5.1 **Accreditation and recognition activity**

<table>
<thead>
<tr>
<th>Course</th>
<th>Type</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Academic year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oct-Dec</td>
<td>Jan-Mar</td>
</tr>
<tr>
<td>Master of Pharmacy (MPharm) degree 4-year</td>
<td>Accreditation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Interim visit</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Master of Pharmacy (MPharm) degree 5-year integrated</td>
<td>Accreditation</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master of Pharmacy (MPharm) degree 2+2 Overseas</td>
<td>Accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overseas pharmacist assessment programme (OSPAP)</td>
<td>Accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent prescribing</td>
<td>Accreditation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Monitoring visit</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Level 3 Pharmacy technician knowledge/competence</td>
<td>Accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recognition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2 medicines counter assistant and dispensing assistant</td>
<td>Accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All events went ahead as scheduled for 2018/19 academic year.

A large number of events in particular quarters is due partly to natural peaks in the accreditation cycles and prescribing events throughout the calendar year. There has been an increase interest from providers in provision of 5-year integrated MPharm degrees, and the increase in the need for pharmacist
prescribers which has led to increased funding for pharmacist prescribing programme places, resulting in interest from new course providers. 52 independent prescribing programmes are currently accredited. From June 2019 prescribing events have begun accreditation to the new education and training standards for pharmacist independent prescribers.

In additional to routine accreditation events, in this quarter the GPhC managed the closure of an MPharm degree taught in part overseas (all affected students were transferred to GB with their agreement) and engaged with a GB university over the teach-out and closure of their MPharm degree.
6. Human Resources

6.1 Headcount Overview

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPhC</td>
<td></td>
</tr>
<tr>
<td>Headcount</td>
<td>230</td>
</tr>
<tr>
<td>Permanent</td>
<td>220</td>
</tr>
<tr>
<td>Fixed Term Contract</td>
<td>10</td>
</tr>
<tr>
<td>Total Leavers</td>
<td>14</td>
</tr>
<tr>
<td>Permanent leavers</td>
<td>12</td>
</tr>
<tr>
<td>Voluntary Turnover – Permanent (Quarter 1)</td>
<td>5%</td>
</tr>
<tr>
<td>Voluntary Turnover – Permanent (rolling 12 months)*</td>
<td>21.9%</td>
</tr>
<tr>
<td>Stability – Permanent staff</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

* 12 months: July 2018 – June 2019

This table summarises the headcount, voluntary turnover & stability position. The total number of leavers for this period was 14, 12 of which were permanent employees, while 2 were on fixed term contracts. The voluntary turnover in the previous quarter (Q4 of 2018/19) was 16.

The turnover rate this quarter was 5% (12 leavers); there were 11 permanent leavers and 1 who left due to redundancy. A higher turnover rate of 7.4% was reported in Q4 of 2018. The voluntary turnover rate for the 12-month period from 01/07/2018 to 30/06/19 is 21.9%. This turnover rate is broadly comparable with the average turnover in the UK at 20.9% in the public sector. The actual number of resignations over the last 12 months, was 53 (50 of those were permanent members of staff**); this represents a voluntary turnover rate of 21.9%. The overall number of leavers in that period was 67.

The stability rate is the number of permanent employees with more than 12 months employment. As at 30th June 2019, there were 184 permanent employees who had more than 12 months’ service. This represents a stability rate of 83.6%, and remains on par with the previous quarter, where we reported a stability rate of 83.0%.

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2 Survey data suggests average turnover in the UK is 20.9% (https://www.xperthr.co.uk/survey-analysis/labour-turnover-rates-xperthr-survey-2019/164515/ last accessed 06/08/19)

** average total permanent headcount figure 228.5.
There were three key reasons given by leavers for their decision to leave; career progression, pay, and workload. Within a relatively small headcount base, career progression can be challenging, but secondments are encouraged across the organisation which can occasionally result in a permanent role. This quarter there were two promotions or opportunities where colleagues secured a new role. More opportunities to stretch colleagues in their roles will be discussed during the mid-year review process this year.

The Pay Salary Matrix is a methodical approach to applying pay awards, it offers greater progression for those at an early point of their careers and seeks to reward staff, based on individual performance. During Q1 the Pay Salary Matrix was communicated and implemented; we did not receive any complaints about the pay award for June 2019.

To ensure that we attract the right talent and minimise labour turnover, it is important that Managers are transparent about role, remuneration package and development opportunities within the GPhC.

### 6.2 Organisational Absence – Absence percentages (April to June 2019)

<table>
<thead>
<tr>
<th>Directorate (average headcount)</th>
<th>Absence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation (230)</td>
<td>3%</td>
</tr>
<tr>
<td>Corporate Resources (32) *</td>
<td>1.3%</td>
</tr>
<tr>
<td>Education &amp; Standards (50)</td>
<td>4.3%</td>
</tr>
<tr>
<td>Fitness to Practise (56)</td>
<td>5.4%</td>
</tr>
<tr>
<td>Insight, Intelligence &amp; Inspection (56)</td>
<td>1%</td>
</tr>
<tr>
<td>People (31)</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

*Whilst the Corporate Resources directorate has been disbanded, the reported figures relate to the time when this directorate was live, until April 2019.*

This quarter, the overall absence percentage remains stable at 3% since the last quarter.

The Fitness to Practise (FtP) Directorate represents the highest absence percentage, this is because of three long term sickness (LTS) cases not related to the workplace, all requiring occupational health intervention. The duration of these cases (varying from a couple of months to up to a year), contribute to a higher absence percentage.
Regular interaction takes place between managers, colleagues and HR Business Partners. As a result, some colleagues have commenced a phased return to help facilitate their return to work on a full-time basis. Formal absence review meetings take place to address absence concerns, discuss preventative actions, proactively support early return to work and reduce absence through a formalised plan and action. In addition to LTS case management, formal absence review meetings have taken place with colleagues through the formalised attendance management policy designed to ensure that all absences are consistently managed; addressing patterns of ad-hoc absences and trends.

An attendance management workshop is being created to help managers manage absences with confidence, in a timely manner and to help identify any trends regarding absences with the support of the HR team.

6.3 Employee Relations

The table below is a summary of the employee relation cases by case type which were live during Q1:

<table>
<thead>
<tr>
<th>Case Type</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases</td>
<td>17</td>
</tr>
<tr>
<td>Absence</td>
<td>11</td>
</tr>
<tr>
<td>Grievance</td>
<td>0</td>
</tr>
<tr>
<td>Disciplinary</td>
<td>0</td>
</tr>
<tr>
<td>Performance</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

There was an increase in the number of employee relations issues since the last quarter, from 11 cases to 17. The category that saw the largest increase was absence; the number of performance matters have also increased. We anticipated an increase in performance related cases following the annual pay review that concluded in June 2019. This is due to colleagues who did not meet expectations as part of the annual performance development review, and were placed on performance improvement plans.
6.4 Learning & Development (L&D)

The online annual Performance Development Review (PDR) process was the main focus for L&D this quarter. We also focused on: designing and delivering the quarterly Corporate Induction; providing additional Disability Awareness training; and, offering Job Evaluation training.

The online PDR was launched one year ago, with a focus on closing the 2018-19 PDRs and setting new objectives for 2019-2020. L&D worked with IT to develop more enhancements to help the system and process be more efficient and user friendly. Enhancements such as improved reporting, automatic reminders and examples of SMART objectives that include our behaviour framework are now included in the online performance tool.

As of the 1st August 2019, 88% of colleagues completed the full 2018-19 PDR cycle, and 83% have captured their 2019-20 PDR objectives. We continue to support colleagues and managers in capturing this year’s objectives.

This quarter we promoted our ‘New Starter Induction’ page on Infopoint, to all people managers. The overall aim was to implement a comprehensive induction process for new employees, that strengthens employee engagement, develops an inclusive community, and retains our talent. Line managers play a vital role in helping new joiners to feel part of their team and the updated ‘New Starter Induction’ page has processes and tools to help both line managers and new starters get off to a great start. We have received positive feedback from a hiring manager who found the tools and guidelines helpful, “…having had a new starter in June and another due here on Monday, the new starter induction page on Info point and the Welcome Pan are both huge improvements and have made the whole process very easy”.

An upcoming initiative between L&D and HR will be to monitor and seek feedback on the updated induction approach and work with IT to create an online process for colleagues on probation to replace the current paper-based approach. This will help to ensure that colleagues on probation are quickly integrated into the organisation/team with their initial objectives.

L&D holds quarterly follow up sessions with our Mental Health First Aiders. Mental Health Awareness week which was held between the 13th & 17th May 2019 was a great opportunity to offer sessions to colleagues on the role of Mental Health First Aiders and show how they can help and offer support. It was also a good time to promote the launch of another e-learning programme called ‘Headtorch’ which provides learners with a better understanding of mental health at work and how to spot signs and symptoms of mental health problems.
Standards for the initial education and training of pharmacists: consultation report

Meeting paper for Council on 12 September 2019

Public business

Purpose

To present Council with a consultation report and equality impact assessment on the GPhC’s recent consultation on revised initial education and training standards for pharmacists and to ask Council to agree next steps to implement new standards

Recommendations

Council is asked to note the consultation report and equality impact assessment and next steps

1. Introduction

1.1 One of the principal functions of the GPhC is to set initial education and training (IET) requirements for its registrants and this is done cyclically. The current set of IET standards for pharmacists were agreed in 2011 and have been in force since then.

1.2 In 2017 the GPhC began to develop new IET standards with a round of 1-2-1 meetings with all schools of pharmacy and other key stakeholders, including Health Education England (HEE), NHS Education Scotland (NES), what is now Health Education and Improvement Wales (HEIW), the Royal Pharmaceutical Society (RPS), the British Pharmaceutical Students’ Association (BPSA), NHS England and the Office for Students (OfS).

1.3 After taking on board feedback from our stakeholders, we drafted new IET standards and consulted on them January-April 2019. There were 650 responses to the consultation: 108 from organisations and 542 from individuals. 144 individuals and representatives of organisations attended three stakeholder events and three patient focus groups. We also presented at 33 events across England, Scotland and Wales, reaching 1,310 stakeholders including pharmacy professionals, education providers, employers, students and pre-registration trainees. Finally, we hosted an online webinar, which was viewed by 900 people.
2. Consultation topics

2.1 As part of the consultation, respondents could comment on any aspect of our proposed standards, but specifically we asked for views on:

- Revising the learning outcomes so that they are more focused on developing clinical and communication skills, while still retaining the critical importance of science;

- Revising the standards for education and training providers, including strengthening our requirements regarding equality, diversity and fairness;

- Having one set of standards and learning outcomes that cover the full period of education and training before initial registration as a pharmacist, with closer integration between academic study and practical experience;

- Strengthening our requirements in relation to selection and admission;

- Strengthening experiential learning and inter-professional learning; and

- Requiring a more rigorous and structured approach to the supervision of learning in practice (currently known as pre-registration training) with more regular and documented progress meetings.

3. Summary outcomes

3.1 We set out emerging findings for Council at the meeting in July. The final analysis supports those key themes. There was broad support for the learning outcomes based on person-centred care, professionalism, professional knowledge and skills; and collaboration. Our emphasis on a clinically relevant curriculum and greater exposure to patients throughout IET was welcomed. Many respondents did, though, emphasise the need for greater detail on the underpinning science to properly reflect current and future challenges and to include more in relation to technology. In addition, the question of whether a newly-registered pharmacist should be able to independently prescribe from day one was also raised as a key issue. There were also views that some learning outcomes needed to be clarified, including on leadership and management.

3.2 There was broad support for the principle of integrating the five years of education and training and strengthening quality assurance throughout this period. Many respondents did, though, raise practical questions of how this would be funded. In relation to selection and admission, there was broad support for proposals to require universities to assess the professional skills and attributes of prospective students as well as their academic qualifications with interactive elements built into the admissions process. There were mixed views about whether the GPhC should be more prescriptive in setting admission standards whereby only those students who achieved the advertised grades should be admitted onto the course and whether unconditional offers should be allowed.
4. **Next steps**

4.1 We intend to engage further with stakeholders given both the potential scale of the changes and the important practical issues, such as funding, that need to be considered before a final set of standards can be agreed.

4.2 In relation to **selection and admission and strengthening equality, diversity and inclusion**, we will work through the detail of the consultation responses to firm up our proposals and will engage with specific stakeholders, including the Pharmacy Schools Council, to finalise our proposals. As these issues do not depend directly on additional funding, we believe the work can be taken forward more quickly with a view to implementation in the 2020/2021 academic year.

4.3 In relation to the **learning outcomes**, we will convene a small stakeholder group to focus on those areas which require greater clarity and detail, primarily **scientific knowledge and skills; technology; prescribing; and leadership and management.**

4.4 In relation to the **integration of education and training**, we will take forward work with universities, students, employers, commissioners, regulators and funders of education and training to develop a better understanding of what ‘integration’ looks like in practice and how it could be achieved. This will take account of the practical suggestions and challenges highlighted in the consultation. In particular, we will initiate further discussions with key stakeholders with a focus on models which would meet our standards and deliver the desired outcomes and what would steps would need to be taken to develop and introduce these models. In doing so, we are continuing to consider the continuum of education and training of pharmacists, reflecting the ongoing discussions about quality-assured post-registration training. up to and beyond initial registration.

4.5 In addition, we are already considering how we can strengthen the quality assurance aspects of the current pre-registration training, specifically a more robust alternative to the current tutor sign-off regime. This was a point a number of respondents highlighted during the consultation.

5. **Communications**

5.1 Communication is essential to the implementation of our proposals and we are developing a communications plan in support of this. We will be discussing our proposals further with the stakeholders referenced in 1.2, as well as other key stakeholders.

6. **Equality and diversity implications**

6.1 A change as significant as the one we are proposing will have equality and diversity implications and we have set these out in Appendix 2. Because there are further conversations to be had before the standards are agreed in their entirety we cannot fully assess the equality and diversity implications of the new standards now but we will keep this aspect of the proposed changes under constant and active review.

7. **Resource implications**

7.1 The resource implications of the proposed changes are mainly for stakeholders and yet to be fully quantified. From the GPhC’s perspective, the resource implications are the costs of
additional stakeholder meetings and accreditation activity, which can be resourced within existing budgets.

8. **Risk implications**

8.1 The main risk in not implementing our new standards is that IET will not be able to deliver the necessary foundation for contemporary pharmacists as scientifically-literate clinicians with an ever-increasing role in the front-line delivery of healthcare. It is clear in what direction the profession is moving and IET must take account of that.

9. **Monitoring and review**

9.1 Once implemented, the implementation of new IET standards will be monitored and reviewed through accreditation.

10. **Recommendations**

Council is asked to note the consultation report and equality impact assessment and next steps.

Mark Voce, Director of Education and Standards & Damian Day, Head of Education
General Pharmaceutical Council

02 September 2019
Consultation on the initial education and training standards for pharmacists: Analysis report
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Executive summary

Background

1. Between January and April 2019, we consulted on changes to our standards for the initial education and training of pharmacists. There were six main areas on which we were seeking views. These were:
   - Revising the learning outcomes so that they are more focused on developing clinical and communication skills, while still retaining the critical importance of science
   - Revising the standards for education and training providers, including strengthening our requirements regarding equality, diversity and fairness
   - Having one set of standards and learning outcomes that cover the full period of education and training before initial registration as a pharmacist, with closer integration between academic study and practical experience
   - Strengthening our requirements in relation to selection and admission
   - Strengthening experiential learning and inter-professional learning
   - Requiring a more rigorous and structured approach to the supervision of learning in practice (currently known as pre-registration training) with more regular and documented progress meetings

2. We delivered the consultation through an online survey and held events for stakeholders and patients and members of the public in England, Scotland and Wales. We also organised many one-to-one meetings with organisations.

3. There were 650 responses to the consultation: 108 from organisations and 542 from individuals.

4. 144 individuals and representatives of organisations attended three stakeholder events and three patient focus groups. We also presented at 33 events across England, Scotland and Wales, reaching 1,310 stakeholders including pharmacy professionals, education providers, employers, students and pre-registration trainees. We also hosted an online webinar, which was viewed by 900 stakeholders.
Key issues raised in responses

General view

5. Our proposals are designed to ensure that pharmacists are equipped with the knowledge, skills, attitudes and behaviours to practise safely and effectively as pharmacy professionals, and that their education and training take into consideration the evolution of pharmacy services. Overall, respondents were broadly supportive of our proposals while making a number of suggestions and raising a number of questions, particularly about how the integration of academic and practical learning would be implemented.

Views on the learning outcomes

6. There was broad support for the learning outcomes set out in the consultation focusing on person-centred care; professionalism; professional knowledge and skills; and collaboration.

7. Most respondents found the learning outcomes clear, ambitious and agreed they captured the knowledge, skills, attitudes and behaviours pharmacists need to practise. They welcomed the stronger emphasis placed on communication with both patients and the multi-disciplinary team, and on clinical skills. Respondents also emphasised the importance of retaining the focus on developing scientific knowledge in pharmacists’ initial education and training.

8. Many detailed responses identified a need to clarify the meaning of certain outcomes and to provide a greater focus on technology and on leadership.

Views on prescribing-related skills

9. A large number of respondents were in favour of our proposals to strengthen prescribing-related skills in the initial education and training of pharmacists. For them, incorporating pre-prescribing skills in the undergraduate degree would enable newly registered pharmacists to train as independent prescribers sooner. These respondents found clinical examination skills and diagnostic skills particularly useful. Several responses also underlined the need to take the use of electronic prescribing systems into consideration. Other respondents thought that newly-registered pharmacists should be prescribing-ready on day one given the changing roles in pharmacy and the important role played by pharmacist prescribers in delivering care.

Views on the standards for providers

10. A large majority of consultation respondents felt that our standards for providers were appropriate and welcomed the strengthened requirements in regard to equality, diversity and fairness and requiring providers to carry out an annual review of student performance and admissions using the protected characteristics defined by the Equality Act 2010.

11. Other respondents made specific recommendations or asked for clarification on the standards focusing on resources and capacity; managing, developing and evaluating initial education and training; curriculum design and delivery; assessment; and support and development for student pharmacists and people delivering initial education and training.

Views on the integration of the five years of initial education and training

12. The majority of consultation respondents supported the principle of integration. Most respondents recognised the benefits to learning from integrating academic study and practical experience. They indicated that it would raise the quality of initial education and training of
pharmacists thanks to the earlier application of knowledge in practice and interactions with patients and health and care professionals. However, many responses were unsure about how integration would be implemented and were concerned about its funding.

**Views on selection and admission requirements**

13. There was broad support for our proposals to require universities to assess the professional skills and attributes of prospective students as well as their academic qualifications with interactive elements built into the admissions process, while recognising that students develop over the course of their education and training. Some respondents questioned how our proposed admissions requirements would apply during Clearing and others mentioned the costs associated with our proposed changes.

14. There were mixed views about whether the GPhC should be more prescriptive in setting admission standards, whereby only those students who achieved the advertised grades should be admitted onto the course, and whether unconditional offers should be allowed. However, the need for consistency between requirements from all education providers was a common theme in many responses.

15. Many respondents also made suggestions on the skills and attributes that should be assessed in applicants and the format of assessments.

16. There was broad agreement that selection and admission procedures should be inclusive and not negatively impact applicants from any groups.

**Views on experiential learning and inter-professional learning**

17. The vast majority of respondents approved of the increase of experiential and inter-professional learning in the initial education and training of pharmacists. This would enable students to achieve a higher level of competence and to become more effective and confident professionals. Respondents highlighted that, as the pharmacist’s role becomes more clinical and embedded in multi-disciplinary teams, it was important for students to be exposed to patients and to interact with colleagues at an earlier stage of their education and training. Many responses underlined the importance of consistency in these two areas between education providers and some respondents asked for clarification of the standard expected.

**Views on learning in practice supervision**

18. Many respondents were in favour of our proposals for learning in practice, agreeing that more regular and documented progress meetings would better support students’ progression, ensure more consistency in the supervision of students and improve the quality of training. There was broad support for adopting a more tailored approach to students’ needs.

19. Many suggestions were made to ensure the continuity of students’ supervision between education and training or between practice supervisors. Propositions were also made regarding the training of supervisors. Respondents also required further clarifications on implementation and expressed concerns about funding.
Key issues raised by country

England

20. Over 80% of consultation respondents were based in England. The section ‘Key issues raised in responses’ is therefore representative of the view of English respondents.

Scotland

21. Scottish respondents proposed to include or strengthen in the learning outcomes, empathy, ethics, dealing with vulnerable groups, resilience, risk management and encouraging the development of a learning culture in the profession.

22. Most Scottish respondents welcomed the integration of academic study and practice learning, mentioning that it would standardise and increase the quality of education and training and ensure close collaboration between stakeholders delivering education and training. Several Scottish respondents also expressed concerns about the implications of integration on students. A few felt that a longer period of learning in practice should take place at the end of the initial education and training to allow students to apply their knowledge in practice.

23. Many Scottish respondents felt that because the pharmacist profession was patient-facing, grades alone could not demonstrate the suitability of an individual for entry into the profession. For them, admission procedures should also assess the skills, attributes, personal qualities, values and behaviours of applicants. They also explained that, in Scotland, unconditional offers were offered after school leavers achieve the required academic criteria.

24. Scottish respondents welcomed our proposals for experiential learning, inter-professional learning and learning in practice. In their view, it was important to adequately train and support supervisors, document progression meetings and quality assure learning in practice.

Wales

25. Welsh respondents welcomed the learning outcomes, commented positively on the people-centred approach and made specific propositions to remove some duplication or to change the level of specific learning outcomes. They also suggested referring to people’s mental health in the learning outcomes.

26. Welsh respondents were supportive of integrating academic study with practice learning and thought that it would increase students’ confidence and communication skills and make them better pharmacists. They were, however, concerned about financial arrangements and the impact of integration on students. Welsh respondents felt it was important for learning in practice placements to take place in several sectors and to establish efficient communication channels between education and training providers.

27. Most Welsh respondents agreed about assessing the skills and attribute of applicants as they felt that only a more holistic approach would ensure that those most suited to the profession entered onto MPharm degrees. They favoured a collaborative approach and proposed to involve employers, patients and members of the public in the interactive components of admission procedures. Many Welsh respondents also felt that unconditional offers should be disallowed.

28. Welsh respondents felt that our proposed changes for experiential and inter-professional learning would be beneficial to future pharmacists.
29. Welsh respondents agreed that regular and documented progress meetings would be beneficial as they would enable supervisors to better support students. A small number of Welsh respondents felt that students should be signed off by more than one supervisor.

Northern Ireland

30. The Pharmaceutical Society of Northern Ireland (PSNI) and the GPhC co-operate in line with the principle of mutual recognition and free movement of students, trainees and pharmacists as between Northern Ireland and Great Britain. The GPhC does not regulate Northern Ireland. We, however, accredit the two MPharm degrees of Queen’s University Belfast and Ulster University and therefore engaged with Northern Irish stakeholders during the consultation.

31. Northern Irish respondents welcomed learning outcomes strengthening clinical, communication and research skills, and felt that the learning outcomes should specifically refer to prescribing or pre-prescribing skills.

32. Regarding selection and admission, many Northern Irish respondents considered that skills and attributes could be learnt for the selection process and that school leavers could be trained to produce appropriate answers. They were concerned that private organisations would start offering training programmes for the applicants who could afford it and that this would create more elitism.

33. There was general agreement in Northern Irish responses for the integration of academic study with practice learning and for strengthening of experiential and inter-professional learning. Northern Irish respondents, however, requested more clarity on funding streams to enable the implementation of these proposals and did not think that standards could be set in isolation to the funding process.

34. Northern Irish respondents also approved of replacing the pre-registration performance standards by the learning outcomes but were unsure about the willingness of the community sector to implement our proposed changes for learning in practice.

Key issues raised by type of respondents

Patients and members of the public

35. Patients and members of the public were in general supportive of the learning outcomes. They welcomed the increased focus on person-centred care and on empowering people in making decisions about their care. They thought more emphasis should be given to empathy, communication and listening skills in the learning outcomes.

36. Patients and members of the public were in favour of integrating academic study with practice learning, felt that students should experience several pharmacy environments during their placements and that placements should be organised from an early stage in the initial education and training of pharmacists.

37. Patients and members of the public agreed with our proposals for selection and admission, although they highlighted that the young age of applicants and widening participation should be taken into account. Many believed that applicants needed to have a minimum level of knowledge and competence to successfully graduate and it was unfair for universities to enrol students who would not be able to graduate. In order not to disadvantage any applicants, patients and members of the public proposed that the applicants, who were not able to travel to
schools of pharmacy for the interactive component of admission procedures, should be assessed through Skype, for example. A significant number of patients and members of the public were against unconditional offers as they felt unconditional offers acted as a disincentive for pupils to achieve their highest standards and affected public confidence in pharmacists.

38. Patients and members of the public supported our proposals regarding experiential and inter-professional learning.

39. They agreed about replacing the four tutor sign-offs by regular progress meeting. In their view, schools monitoring progress meetings would ensure students’ progression and provide mediation in case of disagreements between students and their supervisors.

### Schools of pharmacy

40. The majority of schools of pharmacy felt the revised learning outcomes were largely appropriate and made suggestions for particular additions and clarifications. Their most frequent comment was that the number of learning outcomes focusing on pharmaceutical sciences was too low. They felt that the learning outcomes should specify which scientific disciplines should be covered in the initial education and training of pharmacists. Several schools asked for guidance, examples or expectations on how the learning outcomes should be implemented as they found them non-specific. A small number of schools also mentioned that the shift of several learning outcomes from ‘Shows How’ to ‘Does’ would require further financial investment.

41. Although two-third of schools agreed that students’ learning should be seen as a continuum between academic and practice learning, many of them did not think our proposed changes could be implemented without additional funding. A significant number of schools highlighted the potential additional costs associated with offering an integrated MPharm degree (including administrative management of the programme, appointment of new staff and quality assurance of learning in practice) and were concerned some universities would stop offering MPharm degrees if they considered them as no longer viable. They also did not think students should pay for a fifth year of education and training as it would make pharmacy education much less attractive. Many schools asked for government funding to be explicitly confirmed before making changes to the standards for initial education and training.

42. Several schools also asked for more clarity on responsibilities and accountabilities in an integrated model. They were unsure whose institution would be responsible for approving learning in practice training sites and supervisors, overseeing and quality assuring learning in practice. A number of schools thought a centralised infrastructure for learning in practice should be created. In their view, schools creating their own partnerships with training providers would be resource intensive and would lead to variations in quality of learning in practice. They suggested the creation of a learning in practice infrastructure, as for instance a Deanery infrastructure, which would apply at national or regional levels, to administer, monitor and quality assure learning in practice placements. In the education and training of other professions, Deaneries are local units, which are responsible for implementing specialty/advanced training in accordance with regulators’ approved standards. They can sometimes set local policies and each of them are overseen by a postgraduate dean, who holds ultimate responsibility for the education and training of all students/trainees in that region.

43. Most schools agreed about the value of assessing the skills and attributes of prospective students and several of them said that their admission procedures already included interactive
components. However, some schools were concerned about the financial impact of implementing our proposed changes regarding selection and admission, about the difficulty of organising the face-to-face assessment of applicants during Clearing and about widening participation. A few of them felt that the young age of applicants should be taken into consideration in admission procedures. A number of schools felt that schools should continue to decide their own admission requirements and procedures, including the approach to unconditional offers.

44. Whilst the broad majority of schools agreed with the benefits of experiential learning and interprofessional learning, they asked for clarity about what was expected to meet the standards (volume and nature of such experiences, balance between simulated and in practice learning). Several schools said they believed the GPhC should set minimum requirements for experiential learning and inter-professional learning as they were concerned about inconsistency in delivery across education providers. Another concern shared by many of the schools was the cost associated with implementing our proposed changes in regard to experiential learning and inter-professional learning. They said that this would require additional funding. Several schools also set out that it was sometimes difficult to organise inter-professional learning activities with students from other professions because they had different structures of initial education and training. A number of schools proposed that the GPhC should engage with the regulators of these professions to ensure that the interprofessional emphasis of the proposed standards would be achievable.

45. Most schools agreed with the proposal to replace the four tutor sign-offs during pre-registration training with regular progress meetings as they felt this would improve the supervision of students. They felt the GPhC should set a minimum number of progress meetings or a minimum frequency between meetings as they found the phrase “more regular” too vague. Several schools asked how they should be involved in the progress meetings and expressed concerns about the costs associated with the oversight of the progress meetings. They also felt that the quality of the meetings was more important than their number and proposed that the schools and training providers formulated the purpose of the progress meetings in collaboration with the GPhC and set requirements for supervisors’ training.

46. There was broad agreement on replacing the performance in practice pre-registration performance standards by the learning outcomes to align with modern practice.

Training providers

47. There was broad support for the learning outcomes in training providers’ responses. They particularly approved of strengthening communication and collaboration skills in the learning outcomes, including collaboration with non-professional colleagues.

48. Training providers agreed with the principle of integration as, in their view, it provided a cohesive training programme that enables students’ learning to be applied to practice. However, many training providers were unsure about how integration should be implemented (including in relation to coordinating interaction with several schools and reporting mechanisms on student’s progress between the school, training provider and GPhC). They were also concerned about funding (including whether this might mean students losing the pre-registration salary, as well as the administrative infrastructures required, and training of supervisors) and explained that pharmacists involved in the supervision of students have to balance their teaching role with their
clinical responsibilities. In their view, new appropriate and sustainable funding arrangements needed to be worked through and resolved prior to the implementation of any further changes.

49. Regarding admission requirements, training providers welcomed the assessment of applicants’ skills and attributes and the inclusion of an interactive component in admission procedures. Communication skills and desire to care for patients were particularly important for them. Several training providers asked how they could have an input in admission procedures as they felt they should be involved in those. There was common agreement in training providers’ responses to no longer allow unconditional offers.

50. Overall training providers supported our proposal regarding experiential and inter-professional learning while asking how this would be organised.

51. Many training providers agreed with the proposal to replace the four tutor sign-offs by regular progress meetings and asked for more guidance on frequency of meetings structure, submitting documentation to schools of pharmacy and frameworks to oversee trainees. Several training providers asked how the signing-off of students’ competence at the end of their initial educational and training would be organised between the schools and themselves. Training providers agreed with the proposal to replace the pre-registration performance standards with the learning outcomes but asked for guidance as to how the learning outcomes should be implemented.

**Impact of the proposed changes**

**Patients and members of the public**

52. Many respondents were of the view that our proposed changes would be beneficial for patients and members of the public as they would receive a higher standard of care.

**Students**

53. A common theme was that our proposed changes would be beneficial for the development of students and would increase the quality of the practice of future pharmacists.

54. The main concern of respondents focused on the financial impact of our proposals on students. Respondents were concerned that introducing an integrated degree would mean that students would have to pay for a fifth year of education and training and not receive a salary during their learning in practice. Respondents also anticipated that having several shorter learning in practice placements throughout the five years of initial education and training would mean additional accommodation and travel costs for students. Several respondents worried that international students who wish to obtain a UK MPharm degree, but not undertake their learning in practice in the UK, might decide against studying in the UK.

**Schools of pharmacy**

55. Schools of pharmacy were concerned about the resource and financial impact of our proposed changes. They explained that integration would require them to undertake significant transitions, which would be time and resource-intensive for them. They also anticipated increased costs to change and run their admission procedures; to secure, organise and quality assure experiential learning and learning in practice placements; to appoint and train staff; and to administratively manage programmes. They considered that in the current funding environment it would be hard for them to implement our proposed changes.
Training providers

56. Training providers were concerned about the logistics necessary to train students who were at different stages of their initial education and training, at different times and during shorter placements. They were also unsure about how to work with several schools of pharmacy and worried about the impact of our proposed changes on the workflow of pharmacies. Training providers also mentioned the costs associated with training all staff involved in the supervision of students to a higher standard and increased administrative costs.

57. Training providers also explained that the current length of pre-registration placements enables them to train students to their processes and to assess students’ competence before recruiting them. They were concerned that they would no longer be able to do this because of shorter periods of learning in practice.

58. Several training providers were also concerned that the introduction of shorter periods of learning in practice would mean that students would look for placements close to where they lived and that this would negatively impact training providers located in less populated and rural areas.
People sharing particular protected characteristics

59. We asked consultation respondents and stakeholders whether, in their opinion, our proposals may discriminate or benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. This section summarises respondents’ views.

60. In regard to our selection and admission requirements, respondents mentioned potential impacts on mature applicants (positive impacts of assessing their skills and attributes; negative impacts of stricter academic requirements as they were more likely to have atypical qualifications), on young applicants (who might struggle to demonstrate they have the values, maturity and professional attitudes to become a pharmacist), on people with disabilities (potential for discrimination due to different non-verbal communication skills), on Black, Asian and Minority Ethnic (BAME) groups (concern that the introduction of an interactive component in admission procedure would increase potential bias).

61. Regarding Integration, respondents mentioned potential impacts on mature students (cost of five years of initial education and training, caring responsibilities which make them less able to relocate for learning in practice), disabled people (difficulty to organise and relocate for several learning in practice placements).

62. Several respondents also explained that the support offered by training providers to people with disabilities was sometimes lacking and needed to improve.
Analysis of consultation responses and engagement activities: what we heard

1. Revising the learning outcomes

1.1. 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.

Table 1: Views on the learning outcomes

<table>
<thead>
<tr>
<th>Q1. Considering the full set of learning outcomes in Part 1 of the draft initial education and training standards, to what extent do you agree or disagree that these are appropriate learning outcomes for a pharmacist?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>163 (31%)</td>
<td>24 (24%)</td>
<td>187 (30%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>270 (52%)</td>
<td>70 (69%)</td>
<td>340 (55%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>41 (8%)</td>
<td>3 (3%)</td>
<td>44 (7%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>20 (4%)</td>
<td>5 (5%)</td>
<td>25 (4%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>11 (2%)</td>
<td>0 (0%)</td>
<td>11 (2%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>14 (3%)</td>
<td>0 (0%)</td>
<td>14 (2%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

1.2. As reflected in the figures in Table 1 above, 85% of consultation respondents agreed with our proposed learning outcomes for the initial education and training of pharmacists, and 6% disagreed. Organisational respondents were more in favour of the learning outcomes (93%) than individual respondents (83%).

Table 2: Views on aspects missing or needing to be amended in the learning outcomes

<table>
<thead>
<tr>
<th>Q2. Is there anything in the learning outcomes that is missing or should be changed?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>130 (25%)</td>
<td>72 (71%)</td>
<td>202 (33%)</td>
</tr>
<tr>
<td>No</td>
<td>252 (49%)</td>
<td>28 (27%)</td>
<td>280 (45%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>137 (26%)</td>
<td>2 (2%)</td>
<td>139 (22%)</td>
</tr>
</tbody>
</table>
Q2. Is there anything in the learning outcomes that is missing or should be changed?

<table>
<thead>
<tr>
<th></th>
<th>Individuals N and %</th>
<th>Organisations N and %</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

1.3. As can be seen from Table 2, just under half (45%) of consultation respondents were satisfied with the learning outcomes. A third (33%) of respondents thought that aspects were missing or needed to be amended in the learning outcomes. A larger proportion of organisational respondents felt the learning outcomes should be modified (71%) compared with 25% for individual respondents. However, a larger proportion of individuals felt that they did not know whether the outcomes needed to be modified (26%) compared to organisations (2%).

1.4. We asked the respondents who felt that aspects of the learning outcomes were missing and/or should be amended (responded ‘Yes’ to Question 2) which learning outcomes domains needed to be modified. Table 3 shows the number and percentage of respondents who identified each domain as needing additions and/or amendments.

Table 3: Views on the learning outcomes domains needing addition and/or amendments

<table>
<thead>
<tr>
<th>Q3. Which of the following areas need additions and/or amendments?</th>
<th>Individuals</th>
<th>Organisations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out of all respondents (N and %)</td>
<td>Out of all respondents (N and %)</td>
<td>Out of all respondents (N and %)</td>
</tr>
<tr>
<td><strong>Person-centred care</strong></td>
<td>42 (32%)</td>
<td>43 (60%)</td>
<td>85 (42%)</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td>47 (36%)</td>
<td>41 (57%)</td>
<td>88 (44%)</td>
</tr>
<tr>
<td><strong>Professional knowledge and skills</strong></td>
<td>90 (69%)</td>
<td>60 (83%)</td>
<td>150 (74%)</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>52 (40%)</td>
<td>45 (63%)</td>
<td>97 (48%)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>31 (24%)</td>
<td>17 (24%)</td>
<td>48 (24%)</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td>130</td>
<td>72</td>
<td>202</td>
</tr>
</tbody>
</table>

1.5. 74% of all respondents who responded ‘Yes’ to Question 2 felt that the domain on professional knowledge and skills needed to be amended. There were differences between individuals and organisational responses. More organisational respondents felt that the domain on professional knowledge and skills needed to be amended (83% for organisations compared to 69% for individuals). However, the biggest difference in views between these two group of respondents focused on the domain on person-centred care (60% for organisations compared to 32% for individuals).
1.6. We asked the same respondents (those who responded ‘Yes’ to Question 2 – 33% of survey respondents) to give us a brief description of the additions and/or amendments they thought were needed. These survey respondents also made suggestions for clarification and ways in which the learning outcomes could be strengthened which are detailed in the commentary below.

1.7. Despite expressing the view that the learning outcomes required some modification, a significant number of these respondents expressed broad agreement on the learning outcomes. They welcomed the increased emphasis on people-centred care, clinical skills, and inter-professional working. Many respondents thought the learning outcomes were clear, ambitious, achievable and captured future pharmacists’ practice. Several respondents were pleased that the number of learning outcomes, and so duplication, was reduced. More detailed feedback is given in the commentary below.

1.8. Stakeholders and patients and members of the public who took part in events and focus groups agreed with many of the views of survey respondents. They also provided additional areas for consideration in order to strengthen the learning outcomes. We have captured separate recommendations they made in this section.

**General views**

1.9. Many respondents agreed that the learning outcomes provided an accurate depiction of what a modern-day pharmacist should be capable of. Respondents felt that the learning outcomes would ensure that newly qualified pharmacists are competent and able to function in the workplace. Several respondents also welcomed the fact that the learning outcomes focus on key principles and are constructed in parallel with the Standards for pharmacy professionals.

**Domain 1: Person-centred care**

**People-centred care and communication**

1.10. There was strong support for the increased focus on person-centred care in the learning outcomes. A large number of the respondents who provided open-ended feedback agreed about the importance of empowering people in making decisions about their care. Patients and members of the public who participated in consultation events said there should be greater emphasis on empathy in the learning outcomes.

1.11. Many respondents welcomed the emphasis on communication skills. Patients and members of the public who participated in our engagement events, in particular, expressed that the listening skills and communication skills of some pharmacists currently practising could be improved. For them, pharmacists should ask the right questions and try to understand people’s needs. In their view, pharmacists should listen, adapt to people’s communication needs and take into account non-verbal communication. It was also mentioned in many consultation responses that pharmacists should make sure that people understand the information provided to them. Considering people’s needs rather than solely applying an evidence-based approach was a theme present in many consultation responses. Many respondents explained that pharmacists should be able to identify people’s goals, discuss with people how medicines can contribute to achieve their goals and, to achieve that, they needed to have an understanding of the patient experience.
1.12. A common theme was that pharmacists should be trained to take into consideration cultural and religious differences, disabilities and sexual orientations. Respondents suggested that pharmacists should ask open and inclusive questions and use gender-neutral language. Some respondents proposed to teach the concept of equity to students. In their view, providing equitable services meant acknowledging the different and complex needs of people and adjusting care so that it is relevant to each person’s healthcare needs. It was crucial for respondents that people receive healthcare relevant to their needs rather than based on assumptions made about them.

**Domain 2: Professionalism**

1.13. Patients and members of the public welcomed the learning outcomes that require students to learn to work within the limits of their competence and refer to other health and care professionals when necessary. There was also broad support for the learning outcomes focusing on continuous learning and self-development from both survey respondents and stakeholders.

1.14. Some respondents were of the view that the learning outcomes provided a clear definition of the term professionalism. In their experience, some students and supervisors struggled to understand its true meaning. Other respondents proposed for the learning outcomes to focus more on ethics. They explained that students could find making ethical decisions challenging.

1.15. A few responses pointed out that the distinction between Domain 2 (professionalism) and Domain 3 (professional knowledge and skills) was sometimes artificial as some learning outcomes could be placed in either domain. However, there was a more common agreement that learning outcome 2.13 on infection control would be better placed in Domain 3.

1.16. Several responses mentioned that the concept of resilience should be strengthened in Domain 2.

**Domain 3: Professional knowledge and skills**

**Science**

1.17. Many respondents were of the view that the learning outcomes were very practice-orientated. In their view, more learning outcomes needed to focus on pharmaceutical science. These respondents felt that the term “the science of pharmacy” was too broad and disagreed with scientific knowledge solely being captured in a single learning outcome. A number of respondents suggested the learning outcomes should refer to specific scientific domains. For them, this approach would ensure students acquire a solid scientific foundation enabling them to apply necessary scientific principles, solve problems and handle unexpected situations in their future practice. Several respondents provided specific examples of the scientific knowledge that should be included in the learning outcomes. They mentioned antimicrobial resistance, immunology and polypharmacy and medicine reviews as particular elements that would ensure newly-registered pharmacists were equipped with the necessary knowledge.

1.18. Many responses highlighted that pharmacists are the only members of the healthcare team that have detailed scientific knowledge of medicines and that, for the benefits of patients, pharmacists should retain that expertise.
Clinical skills

1.19. There was broad support for the stronger emphasis on clinical skills in the learning outcomes. Many respondents agreed with the inclusion of learning outcomes on consultation, diagnostic and physical examination skills.

1.20. A large number of respondents were also in favour of our proposals to strengthen prescribing-related skills in the initial education and training of pharmacists. For them, incorporating pre-prescribing skills in the undergraduate degree would enable newly registered pharmacists to train as independent prescribers sooner. These respondents found clinical examination skills and diagnostic skills particularly useful.

1.21. Even though a significant number of respondents agreed about increased clinical skills in the learning outcomes, a few of them were concerned that it would be difficult to gain these skills in some training environments. They questioned how clinical skills should be delivered and met at the level ‘Does’ on the Miller triangle\(^1\).

1.22. There was a small number of respondents who were concerned about physical examinations. They questioned whether a pharmacist would be expected to carry out a physical examination to the same standard than a doctor and worried about stretching pharmacists’ responsibilities without appropriate training. A small number of respondents also queried whether there was a sufficient number of pharmacists with these skills to support students in developing these skills.

1.23. The respondents who disagreed with the increased focus on clinical skills explained that not all pharmacists would work in patient-facing roles. For them, pharmacists should remain the experts in the science of medicines. They were concerned that the basics of science would be diluted among other skills and that pharmacists would become generic clinicians. These respondents were in favour of learning outcomes with a stronger focus on the underlying science needed to inform people-centred care and collaboration.

Research activities

1.24. A small number of respondents questioned the importance of students engaging in research activities even if they agreed students should understand research, research techniques and how research is applied to practice. They proposed that students should be involved in clinical audit activities instead.

1.25. For other respondents, it was crucial for pharmacists to be taught to be critically reflective of their work and the work of others. In their view, a strong foundation in practice-based research would support the development of a profession which is thoughtful, sceptical and keen to evolve.

Awareness and usage of technologies

1.26. Many respondents agreed with our proposal to introduce learning outcomes focusing on technologies.

1.27. Several responses underlined the need to focus on the use of data to improve care. They explained that the healthcare system is changing fast and that pharmacists play a more important role in public health and population level planning. Respondents proposed that more

\(^1\) Consultation on initial education and training standards for pharmacists (page 18)
specific learning outcomes were needed to cover data, IT literacy and the use of electronic prescribing systems.

1.28. A few respondents also believed that technologies empowered pharmacists to conduct more meaningful diagnoses with favourable clinical outcomes and felt that digital diagnosis should become an integral part of pharmacy.

**Domain 4: Collaboration**

1.29. A few respondents were of the opinion that, because of its small number of learning outcomes and, in comparison to other domains, Domain 4 (collaboration) looked unbalanced.

**Collaboration with other professions**

1.30. There was broad support for the changes proposed which enable shared learning between professions and future pharmacists to work more closely with other health and care professionals. Respondents explained that pharmacists work as part of multi-professional teams in all care settings. For them, the ability to work well in teams was paramount to supporting the safe and effective management of medicines.

1.31. However, several respondents felt that MPharm degrees should emphasise that pharmacists work within and across sectors, but also that not all of pharmacists’ interactions are with other health or social care professionals. In their view, students should also be prepared, for instance, to work with receptionists and for service managers and commissioners.

**Leadership**

1.32. Several responses welcomed the addition of clinical leadership in the learning outcomes. Event participants particularly approved of this addition.

1.33. A few respondents felt that the leading role pharmacists will have in future healthcare settings was not captured strongly enough in the learning outcomes. For them, leadership was especially important for pharmacists entering community pharmacy, as they may be expected to lead pharmacy teams from day one. This reflected the ambitions articulated in the NHS Long-Term Plan and the possibility of leadership roles within schools of pharmacy, such as Head of School (or equivalent across higher education institutions) was mentioned as an example.

1.34. Other respondents, however, felt that expecting undergraduate students or newly registered pharmacists to demonstrate ‘effective leadership’ or ‘clinical leadership’ would be too much.

1.35. A small number of respondents asked for a definition of clinical leadership as they felt it could be interpreted differently by providers and students.

**Level of the learning outcomes**

1.36. Respondents had diverging views in regard to the level of the learning outcomes on the Miller triangle. A few respondents felt that all learning outcomes should be set at ‘Does’. Others proposed to change a few learning outcomes from ‘Does’ to ‘Shows how’, as it would be difficult for students to ‘repeatedly and reliably’ demonstrate their competence in some instances (for example learning outcomes focusing on safeguarding and on first aid).

1.37. A few responses mentioned that the term ‘understand’ should not be used in the learning outcomes as it is too difficult to measure.
What is missing from the learning outcomes

1.38. Several respondents were of the opinion that the MPharm degree currently does not appropriately cover management skills when many qualified pharmacists are expected to run a pharmacy and to manage staff and resources. They therefore suggested that the learning outcomes should cover management and organisational skills. In their view, pharmacists’ training also needs to entail negotiating skills, people and project management skills.

1.39. A small number of respondents pointed out that currently some pharmacists are uncomfortable when making decisions in areas of uncertainty. Others mentioned that some pharmacists do not always understand the need to work outside guidelines to prioritise patient safety. They felt these two elements needed to be covered in the learning outcomes.

1.40. A few respondents mentioned that the learning outcomes only referred to the physical needs of patients. They were of the view that people’s mental health needs should also be taken into consideration in the learning outcomes. They explained that currently many newly qualified pharmacists report feeling that their knowledge of mental health is not at the same level as their knowledge of physical health.

1.41. A few responses also mentioned that other sectors in which pharmacists practise should be taken in consideration in the learning outcomes. For instance, they referred to industry and academia.

Implementing the learning outcomes

1.42. Several respondents asked how and when the learning outcomes should be demonstrated and evaluated. Others asked for the GPhC to issue minimum expectations so that education and training providers know the level expected from students.

1.43. Some respondents were concerned that the learning outcomes focussed on the five years of education and training. With several learning outcomes changing level from ‘Shows how’ to ‘Does’, several schools of pharmacy explained that the change in assessment techniques would require further financial investment.

1.44. A number of respondents were also concerned that students who do not intend to practise as pharmacists or who do not want to complete their learning in practice in the UK might be negatively impacted by the fact that the learning outcomes were set for the five years of initial education and training. They were concerned these students would no longer consider studying pharmacy in the UK.
2. Revising the standards for providers

Table 4: Views on the standards for providers

<table>
<thead>
<tr>
<th>Q4. Considering the full set of standards and criteria in Part 2, to what extent do you agree or disagree that these are appropriate for the initial education and training of pharmacists?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>147 (28%)</td>
<td>21 (21%)</td>
<td>168 (27%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>258 (50%)</td>
<td>63 (62%)</td>
<td>321 (52%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>58 (11%)</td>
<td>4 (4%)</td>
<td>62 (10%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>27 (5%)</td>
<td>11 (11%)</td>
<td>38 (6%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>10 (2%)</td>
<td>0 (0%)</td>
<td>10 (2%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>19 (4%)</td>
<td>3 (3%)</td>
<td>22 (4%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

2.1. As reflected in the figures in Table 4 above, a majority of both individuals and organisations (79%) agreed that our proposed standards for providers were appropriate for the initial education and training of pharmacists. A slightly higher proportion of organisational respondents were in favour of the standards (83%) compared with individual respondents (78%).

Table 5: Views on aspects missing or needing to be amended in the standards for providers

<table>
<thead>
<tr>
<th>Q5. Is there anything in the standards or criteria that is missing or should be changed?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>97 (19%)</td>
<td>69 (68%)</td>
<td>166 (27%)</td>
</tr>
<tr>
<td>No</td>
<td>275 (53%)</td>
<td>20 (20%)</td>
<td>295 (48%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>147 (28%)</td>
<td>13 (13%)</td>
<td>160 (26%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

2.2. As can be seen from Table 5, 48% of respondents did not think anything was missing or needed to be changed from the standards for providers, whereas 27% felt that they needed to be amended. A much larger proportion of organisational respondents felt that aspects of the standards should be modified (68% compared with only 19% of individuals). A higher proportion of individuals felt that they did not know whether anything was missing or needed to be changed in the proposed standards (28%) compared with organisations (13%).
2.3. We asked the respondents who felt that aspects of the standards were missing and/or should be amended (responded ‘Yes’ to Question 5) which standards needed to be modified. Table 6 shows the number and percentage of respondents who identified each standard as needing additions and/or amendments.
Table 6: Views on the standards needing addition and/or amendments

<table>
<thead>
<tr>
<th>Q3. Which of the following areas need additions and/or amendments?</th>
<th>Individuals</th>
<th></th>
<th>Organisations</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out of those who responded 'Yes' to Q2 (N and %)</td>
<td>Out of all respondents (N and %)</td>
<td>Out of those who responded 'Yes' to Q2 (N and %)</td>
<td>Out of all respondents (N and %)</td>
<td>Out of those who responded 'Yes' to Q2 (N and %)</td>
<td>Out of all respondents (N and %)</td>
</tr>
<tr>
<td>Selection and admission</td>
<td>43 (44%)</td>
<td>43 (8%)</td>
<td>42 (61%)</td>
<td>42 (41%)</td>
<td>85 (51%)</td>
<td>85 (14%)</td>
</tr>
<tr>
<td>Equality, diversity and fairness</td>
<td>18 (19%)</td>
<td>18 (3%)</td>
<td>19 (28%)</td>
<td>19 (19%)</td>
<td>37 (22%)</td>
<td>37 (6%)</td>
</tr>
<tr>
<td>Resources and capacity</td>
<td>25 (26%)</td>
<td>25 (5%)</td>
<td>39 (57%)</td>
<td>39 (38%)</td>
<td>64 (39%)</td>
<td>64 (10%)</td>
</tr>
<tr>
<td>Managing, developing and evaluating initial education and training</td>
<td>25 (26%)</td>
<td>25 (5%)</td>
<td>27 (39%)</td>
<td>27 (26%)</td>
<td>52 (31%)</td>
<td>52 (8%)</td>
</tr>
<tr>
<td>Curriculum design and delivery</td>
<td>40 (41%)</td>
<td>40 (8%)</td>
<td>40 (58%)</td>
<td>40 (39%)</td>
<td>80 (48%)</td>
<td>80 (13%)</td>
</tr>
<tr>
<td>Assessment</td>
<td>31 (32%)</td>
<td>31 (6%)</td>
<td>28 (41%)</td>
<td>28 (27%)</td>
<td>59 (36%)</td>
<td>59 (10%)</td>
</tr>
<tr>
<td>Support and development for students and people delivering initial education and training</td>
<td>23 (24%)</td>
<td>23 (4%)</td>
<td>24 (35%)</td>
<td>24 (24%)</td>
<td>47 (28%)</td>
<td>47 (8%)</td>
</tr>
<tr>
<td>Learning in practice (pre-registration)</td>
<td>47 (48%)</td>
<td>47 (9%)</td>
<td>48 (70%)</td>
<td>48 (47%)</td>
<td>95 (57%)</td>
<td>95 (15%)</td>
</tr>
<tr>
<td>Learning in practice (pre-registration) supervision</td>
<td>42 (43%)</td>
<td>42 (8%)</td>
<td>37 (54%)</td>
<td>37 (36%)</td>
<td>79 (48%)</td>
<td>79 (13%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>130</td>
<td>519</td>
<td>72</td>
<td>102</td>
<td>202</td>
<td>621</td>
</tr>
</tbody>
</table>
2.4. Respondents who responded ‘Yes’ to Question 5 felt that the domains on learning in practice supervision (57%), selection and admission (51%) and curriculum design and delivery (48%) needed to be amended. Respondents were least likely to say that that the domain on equality, diversity and fairness should be amended, with only 22% of respondents suggesting this.

2.5. There were also differences between individuals and organisational responses. More organisational than individual respondents felt that the domains on resources and capacity (57% compared to 26%) and on learning in practice (70% compared to 48%) should be modified.

2.6. We also asked the respondents who felt that aspects of the standards were missing and/or should be amended (responded ‘Yes’ to Question 5 – 27% of respondents) to give us a brief description of the additions and/or amendments they thought were needed. Their comments are detailed in the commentary below. The views of consultation event participants are also captured in this section as similar views were brought up.

2.7. The responses focusing on integration of study and practical learning and on selection and admission requirements have been analysed later in the report in the sections focusing on these topics (see sections 7, 8 and 9).

Equality, diversity and fairness

2.8. There was broad support for strengthening requirements in regard to equality, diversity and fairness. Many respondents welcomed schools having to carry out a review of student performance and admissions using the protected characteristics defined by the Equality Act 2010. A few respondents suggested specifically mentioning the protected characteristics, as defined in the Equality Act 2010. They were concerned that when referring to equality in general terms, certain protected characteristics might be forgotten or overlooked.

2.9. A small number of respondents proposed that education and training providers should seek students’ feedback early on in the academic year or during the period of learning in practice to be able to act on it if needed. A few respondents also suggested that providers should proactively support the groups who are less successful in their education and training.

2.10. Pharmacists who mentioned having a disability explained that they received appropriate support while at university, but when they started their pre-registration placement their capacity had been questioned and they were not supported. Other respondents mentioned that training providers should be informed, in advance of learning in practice periods, of any reasonable adjustment students need.

Resources and capacity

2.11. A number of respondents were unsure about how to implement requirements on resources and capacity. Several of them asked what was an ‘appropriate level of resource’ to deliver a sustainable and accreditable initial education and training programme. A few others asked for clarifications on staff complement for the delivery of each component of the integrated period of initial education and training.

2.12. Some of the responses also focused on education and training premises. Several respondents asked who was responsible for determining premises are fit for purpose and how this should be measured. Many felt that some level of accreditation and standardisation would be necessary to ensure consistency across providers and countries.
2.13. A small number of respondents were of the opinion that a ratio of practising pharmacists to academic staff should be set to ensure the knowledge delivered in MPharm degrees is current and relevant to practice.

Managing, developing and evaluating initial education and training

2.14. A common theme among the responses on managing, developing and evaluating initial education and training, was for guidance to support implementation to ensure consistency across providers.

2.15. Several respondents asked for lines of responsibility to be explicitly detailed. Other respondents were of the opinion that quality assurance processes were needed nationally. They explained that training providers would be taking students from different years and at different times. In their view national mechanisms would ensure consistent quality of training.

2.16. Several responses focused on providers having to demonstrate how users’ views are used to develop initial education and training. A few respondents believed that all stakeholders’ views should be considered. Others felt strongly about taking into consideration current and previous student feedback. They agreed providers should be able to evidence how they collate and analyse student feedback and demonstrate how they address issues raised.

2.17. A few respondents pointed out that schools, in order to respect GDPR policies, did not keep data for a long period of time. They questioned how this would impact data requests from the GPhC.

Curriculum design and delivery

2.18. A significant number of responses focusing on curriculum and delivery also focused on how to implement our requirements. A few respondents requested clarification on simulated learning environments, number of assessment re-sits permitted, and delivering the learning outcomes in different settings.

2.19. There was broad agreement that as a general principle, all assessments must be passed.

2.20. When engaging with a range of stakeholders to develop a curriculum, a few respondents mentioned that care must be taken to ensure that a major stakeholder, such as an influential employer in a neighbourhood, does not unduly influence the content of the course.

Assessment

2.21. Taking into consideration the much-increased involvement of training providers in the initial education and training of pharmacists, respondents had many queries in relation to the assessment of students.

2.22. Respondents asked how training providers would assess students’ competence, how students’ assessment would be jointly led between education and training providers, how education and training providers would communicate on students’ progression and who would be responsible for the final sign-off of students.

2.23. Other queries focused on the training of examiners and assessors, on liability in cases of errors, on the assessment of inter-professional training and on the range of assessment approaches that could be used.
Support and development for student pharmacists and people delivering initial education and training

2.24. A small number of respondents felt that it was important for students to have a pharmacist mentor at all times. However, others explained that current tutors are not always pharmacists. They welcomed the requirement for students to have access to pharmacy professionals who act as role models and mentors, but pointed out the small number of pharmacists in senior management positions in schools.

2.25. A few respondents asked how training providers would support staff in supervising roles. They requested guidance on induction and training materials for teams involved in delivering experiential learning and learning in practice.

Learning in practice

2.26. Many responses questioned how learning in practice should be implemented and what the responsibilities placed on stakeholders involved.

2.27. Some respondents asked for guidance regarding the number and length of learning in practice blocks. Others suggested translating the 52 weeks requirement into days, as more suitable for a model entailing shorter and more frequent placements. A small number of respondents were of the opinion that 52 weeks of learning in practice was not enough.

2.28. A large number of respondents proposed that learning in practice takes place in at least two sectors. Some respondents referred to the Welsh multi-sector pre-registration model and explained that students benefit more from a multi-sector approach. Others explained that a multi-sector approach would enable students to be exposed to a wider range of patients in a variety of environments and to learn how to deal with different kinds of patients with different, and at times complex, needs. Respondents generally agreed that through this approach students would gather a better understanding of the whole patient journey and of the roles of other health and care professionals. A few respondents made a more specific suggestion, asking that all students have at least one hospital experience, so that they understand a patient’s journey through hospital.

2.29. Many responses focused on collaboration between education and training providers. A number of training providers were unsure about how they would accommodate the training of students from different schools and with different training needs. They felt that periods of learning in practice needed to be coordinated so they would not impact on workplace workflows. Many respondents (mainly education and training providers) proposed the creation of regional structures or frameworks to ease collaboration between stakeholders and ensure consistent quality. Several other respondents also asked about the quality assurance of learning in practice training locations. They wondered whether this would be carried out by schools or by the GPhC.

2.30. A small number of respondents were unclear about the distinction between learning in practice and experiential learning.

Learning in practice supervision

2.31. There were many requests for clarity and suggestions made regarding learning in practice supervision.
2.32. Respondents had diverging views on who should be able to supervise students. Some of them felt that designated learning in practice supervisors should only be pharmacists. Others explained that, as there is a strong emphasis on inter-professional learning in the standards, it would be appropriate for students to be supervised by other health and care professionals. They explained this would also increase the availability of placement opportunities for students.

2.33. A few respondents asked whether our training requirement of supervisors would apply to all supervisors, including other health and care professionals, or just to designated learning in practice supervisors.

2.34. Several respondents suggested that students’ work-based experiences should be overseen by a school-based supervisor to ensure students meet the learning outcomes to the standard required. Others felt that schools should regularly check in with students to ensure the quality of their learning in practice progression.

2.35. There were also diverging views in regard to who should sign off students’ competency and fitness to practise. Some respondents mentioned that schools signing off students could create a potential conflict of interest. They were concerned that schools might let some students graduate, even if they do not meet all the learning outcomes. Other respondents were of the view that designated learning in practice supervisors should not sign off students because of the relationship they build with them. These respondents thought that different individuals should mentor and assess students. Several other respondents felt that sign-offs should be jointly carried out by schools and supervisors and take place after each period of learning in practice.

2.36. Some respondents proposed that students have more than one pharmacist signing them off, or that they are signed off by independent assessors. Others made propositions for more robust and evidence-based mechanisms to evaluate students. They proposed progression reports and feedback from all individuals involved in a student’s training to be collected, peer reviewed and assessed. In their view this would ensure that the quality of training is always maintained and enable a more holistic assessment of a student’s preparedness for practice.

2.37. Several respondents mentioned that assuring the quality of learning in practice supervision was beyond the current ability and capacity of schools of pharmacy, unless additional funding was made available to enable them to recruit staff to supervise this aspect of the training.
3. Integrating the five years of initial education and training

Table 7: General views on setting integrated standards for the five years of initial education and training

<table>
<thead>
<tr>
<th>Q7. Do you agree or disagree that we should set integrated standards for the five years of education and training?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>244 (47%)</td>
<td>38 (37%)</td>
<td>282 (45%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>155 (30%)</td>
<td>39 (38%)</td>
<td>194 (31%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>37 (7%)</td>
<td>8 (8%)</td>
<td>45 (7%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>27 (5%)</td>
<td>10 (10%)</td>
<td>37 (6%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>48 (9%)</td>
<td>5 (5%)</td>
<td>53 (9%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>8 (2%)</td>
<td>2 (2%)</td>
<td>10 (2%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

3.1. As reflected in the figures in Table 7 above, a majority of both individuals and organisations (77% and 75% respectively) supported our proposal to integrate academic and practice learning, and 15% of respondents disagreed with this proposal.

3.2. Just over two-thirds of respondents to the consultation survey provided open-ended comments to the consultation questions on integration. A significant number of these were supportive of integration, mentioning that integration would raise the standards of education and training and enable students to apply their knowledge in practice. This view was also frequently expressed during stakeholder meetings and events. However, many respondents were unsure about the implementation of this proposal, including the resources available to fund integrated programmes and expressed concerns about the potentially negative impact integration could have on students, schools of pharmacy and training providers.

Raising the quality of initial education and training and standardising students’ experiences

3.3. There was broad agreement that integration would raise the quality of the initial education and training of pharmacists. Respondents were of the view that integration would enable students to progress faster, acquire a better skill set and become better pharmacists. They also welcomed students having a greater and earlier exposure to real-life practice. Respondents thought this would enable students to embody their roles, develop their communication skills, feel responsible and build their confidence earlier on, while undertaking clinical and patient-facing activities and collaborative work with health and care professionals. Several respondents also mentioned that integration would help students to develop professionalism at an early stage.

3.4. Several respondents pointed out the current variation in the quality of registered pharmacists’ practice. In their view, integration would ensure a more consistent quality in students’
learning/training and would raise the practice of pharmacists, enabling them to be better prepared for the workplace and be ready for their roles from day one. Many respondents also mentioned variations in terms of pre-registration experience. They welcomed the possibility of strengthening the quality assurance of placements and felt that integration would standardise workplace experience as schools would be able to train, support and assess tutors.

3.5. In general, respondents felt that integration would ensure a more coordinated and collaborative approach across providers and ensure that more cohesive training programmes are developed for students to meet the learning outcomes.

**Application of knowledge in practice**

3.6. From an educational perspective, many respondents explained that integration facilitates the consolidation of learning through earlier clinical application of underpinning knowledge in a live practice environment. For them, student pharmacists would gain more real-world experiences to contextualise their academic learning and be able to practically apply their learning in the context of health and care delivery.

**Interaction with patients**

3.7. Respondents agreed with our proposed changes in that pharmacists’ training should be more people-centred and should entail early interactions with patients and members of the public. In their opinion, this would increase students’ confidence, as this is something current students are sometimes lacking. Other respondents agreed that more practical experience should be incorporated into the MPharm degree as it is the practice element which enables students to move to the level of competency ‘Does’ on the Miller triangle.

3.8. A few survey respondents and stakeholder event participants pointed out that pharmacy is one of the only health and care professions where education and training are separate and independent from each other. They approved of aligning the structure of the initial education and training for pharmacists to the ones of other patient-facing professions.

**Clear progression and better support for students**

3.9. Several respondents appreciated being able to see the learning trajectory of student pharmacists over the five years of initial education and training. For them, integration would allow students a clear progression throughout the five years, from baseline to practice, and make sure students’ learning is coherent, constructive and supported in all settings. Indeed, several respondents felt that student pharmacists’ supervision would be improved as more than one tutor would support students. Several respondents mentioned that integration would enable schools and tutors to identify student pharmacists’ strengths and weaknesses at an early stage and enable them to adequately support student pharmacists to develop.

3.10. Several respondents thought that integration will ease the current transition students experience when they start their pre-registration training. They explained that this transition can sometimes be daunting for students who don’t have much contact with patients during the four years of their MPharm degree. A few respondents also mentioned that, thanks to the earlier exposure to practice, students will be able to identify at a much earlier stage if they are not suited to the role of a pharmacist.
Support for the greater emphasis on clinical skills

3.11. Many respondents mentioned that the roles and responsibilities of pharmacists have expanded, including increasing clinical responsibilities. For them, integration would enable future pharmacists to deliver much more clinical services and to be better prepared to meet the needs of the evolving healthcare landscape across the UK.

Financial and resource implications

3.12. Even though many respondents were supportive of integration, many respondents were concerned about the financial impact of our proposal on students. They felt that this may mean that students would have to pay for a fifth year of education and training and gave the view that students should still receive a salary or a bursary during their learning in practice. Several respondents also pointed out that students are likely to have increased travel and accommodation costs due to shorter learning in practice placements in different locations. They supposed that some students would choose training sites which are closer to where they live to reduce costs. Several respondents were concerned that an increased financial burden placed on students would reduce the number of people wanting to study pharmacy and make the MPharm degree less attractive.

3.13. Schools were concerned about the costs and resource implications linked to the implementation of integration, the monitoring, supervision of tutors and the quality assurance of learning in practice. They explained that they don’t currently have the capacity or resources to implement our proposal, as they would need to recruit staff and to change their administrative infrastructures.

3.14. Several training providers also mentioned the need for additional resources to implement our proposals in the workplace. They expressed concerns about additional strains being placed on workplaces as staff will have to spend more time training and supervising students. Training providers also raised questions about how they would plan shorter placements throughout the year and co-ordinate the training needs of students from different schools. They anticipated that managing the training of several students with different development needs would be challenging.

3.15. A common query was how integration would be funded with some respondents adding that current funding models provide real constraints. It was suggested that only substantial investment in pharmacists’ education and training would enable a successful implementation of our proposal. Respondents were concerned about a reduction of training places if the necessary funding was not available and suggested that discussions with funding bodies should take place.

Concerns linked to learning in practice

3.16. Several respondents were concerned about integration resulting in many short placements. In their experience, students need time to settle in the workplace before developing skills and too short placements could have a detrimental impact on their development. They preferred longer periods of practical learning to give students time to build confidence and to gradually increase their responsibilities. A few other respondents were of the view that a longer placement at the end of the five years would ensure a better continuum from students to practitioners.
3.17. A small number of respondents were unsure about introducing placements too early as they felt students would not have the depth of academic learning to make full use of their placements. However, other respondents believed that in order to meet the future workforce and population health needs, all MPharm degrees should plan clinical exposure from day one, to allow students to be upskilled at an earlier stage.

3.18. There were a few concerns that changing the status of trainees, from employees to students, would have a negative impact on students’ attitude or mindset during their learning in practice. A small number of respondents suggested that students might become less responsible because they would have less exposure to regular working routines and may not be paid for their work.

3.19. The majority of the respondents who disagreed with our proposal thought that the 4+1 model should be kept and many suggested that only experiential learning and pre-registration requirements should be strengthened, as well as their quality assurance. A few respondents were concerned that if a model akin to the current 4+1 MPharm degree remained (i.e. a 5-year programme with a significant final year placement), then the pressure to achieve the five-year learning outcomes would still be within the final twelve months. They felt that the GPhC should clearly state which learning outcomes should be achieved before the ‘break point’ of 4 years (before the final clinical placement).

3.20. Some respondents were opposed to our proposal because they did not think integration would raise the quality of the initial education and training of pharmacists and harmonise students’ experiences. Other respondents were opposed to the greater focus on clinical skills. They explained that not all students will become pharmacists in the NHS or work with patients. In their view, the integration of academic and practical learning would make the MPharm degree less attractive for these students, as well as for international students wishing to study in the UK and complete their practical training overseas.
4. Selection and admission requirements

Table 8: Views on assessing the skills and attributes of prospective students as part of their admission procedures

<table>
<thead>
<tr>
<th>Q8. Do you agree or disagree with our proposal to require schools of pharmacy to assess the skills and attributes of prospective students as part of their admission procedures?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>289 (56%)</td>
<td>58 (57%)</td>
<td>347 (56%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>137 (26%)</td>
<td>30 (29%)</td>
<td>167 (27%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>36 (7%)</td>
<td>5 (5%)</td>
<td>41 (7%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>29 (6%)</td>
<td>3 (3%)</td>
<td>32 (5%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>22 (4%)</td>
<td>4 (4%)</td>
<td>26 (4%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6 (1%)</td>
<td>2 (2%)</td>
<td>8 (1%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

4.1. As reflected in the table above, 83% of consultation respondents were in favour of assessing the skills and attributes of prospective students. The views of individual and organisational respondents were similar (82% and 86%). 9% of consultation respondents disagreed with that proposal.

4.2. Just over half of respondents provided open-ended feedback to this question. Overall they agreed with a more holistic assessment of applicants’ potential to ensure students successfully register with the GPhC. They discussed the skills and attributes that should be considered and agreed on the importance of admission procedures being inclusive. The views of event participants were similar to the ones of survey respondents and are also captured in this section.

Assessing the skills and attributes of prospective students

4.3. There was broad support for taking into consideration more than the academic capabilities of applicants during admission procedures. Respondents explained that the more academically accomplished students do not always make the best pharmacists. Many respondents also mentioned that solely considering applicants’ qualifications does not provide a sufficient picture of an applicant’s readiness to study on an MPharm degree.

4.4. Other respondents agreed with the assessment of applicants’ suitability to work as a pharmacist because they thought that currently some students can lack communication skills, empathy or do not always have the passion and drive to study pharmacy. Many respondents were of the opinion that personal values and behaviours are developed prior to university. These respondents agreed that assessing the skills and attributes of prospective students would strengthen the quality of pharmacy students admitted onto MPharm degrees. For them, only
students possessing the personal and professional values required to deliver person-centred care and to collaborate with others should be granted entry onto MPharm degrees.

4.5. A large number of respondents agreed with the proposals to assess the skills and attributes on admission as they felt that only the right applicants should be accepted onto an MPharm degree, even if this means a smaller overall number of students. In their view, the assessment of an applicant’s ability to attain the level expected from the profession needs to be rigorous to help standardise the baseline attributes of students recruited into the profession. It was pointed out that the role of pharmacists has evolved significantly in response to different pressures and it was normal for the profile of students to align to these changes. Other respondents were of the view that schools currently accept too many students, even when some of them would not be able to graduate.

4.6. Some respondents expressed that it was unfair to give students a place on an MPharm degree if they were unlikely to meet the standards required to register or in pharmacists who lack the ability to deliver compassionate care to patients. They were of the view that admission procedures should have the objective to identify the applicants who would be able to successfully graduate and become pharmacists. In their view, this would only be possible if the skills and attributes of applicants are taken into consideration in admission procedures. Respondents agreed that a more robust admissions procedure, which better reflects the requirements of the course, would reduce the number of students retaking years of study, failing to complete the course, as well as potential issues arising during or after registration.

Skills and attributes which should be assessed

4.7. When mentioning the skills and attributes that they thought should be assessed in applicants, many respondents underlined the importance of communication, interpersonal skills and social awareness. For them, it was imperative that pharmacists are able to explain their knowledge to patients and to communicate effectively with people from all backgrounds. Respondents also agreed that pharmacists need to be able to engage with multi-disciplinary teams. They explained that inter-professional working is much more prevalent in the workplace today and that students should be adequately prepared for it. Several respondents proposed the written and spoken English of applicants (international and home applicants) should be assessed, as they thought their communication was sometimes problematic.

4.8. There was broad agreement about considering the motivation of applicants to study on an MPharm degree or to become a pharmacist. Some respondents felt that too many applicants who do not know what a pharmacist does or have little interest in becoming a pharmacist are currently admitted onto MPharm degrees. They were particularly concerned about applicants who see an MPharm degree as a 'plan B' to medicine and dentistry.

4.9. Many respondents also felt that applicants should be interested in working with patients. Several pre-registration tutors explained that some of the trainees they supervised were lacking a people-centred approach. In their view, most pharmacists will operate in patient-facing roles and it was essential to ensure applicants are interested in working with people. Respondents explained that pharmacists need to be compassionate, caring, empathetic and able to emotionally connect with people.
4.10. Some respondents proposed the assessment of numeracy skills of applicants, while others suggested having mechanisms to ensure that applicants are sufficiently mentally and emotionally resilient to work in the profession.

**Ensuring admission procedures are inclusive**

4.11. In general, respondents agreed that admission procedures need to balance a high standard of admissions with ensuring widened opportunities. There was broad agreement that the assessment of applicants should ensure that no group is disadvantaged by admission procedures.

4.12. Some respondents felt that assessing the skills and attributes of applicants would mean that applicants with prior experience of the pharmacy sector would be appropriately considered.

**Concerns about assessing the skills and attributes of applicants**

4.13. A number of respondents were concerned that it was difficult to ascertain accurately a person’s set of skills, attributes and values at the point of entry to a degree at the age of 17/18 and that schools’ admission procedures should be mindful that some concepts, such as professionalism or patient-centred care, are potentially more “difficult” for some applicants.

4.14. Many respondents also pointed out that students mature considerably between the ages of 17 and 22. They explained that students’ social and interpersonal skills develop significantly throughout their studies. For them, some skills can be learned. These respondents therefore did not think that assessing all skills and attributes required of a registered pharmacist at admission was appropriate. They felt that admission procedures should be designed to accept onto MPharm degrees the candidates who have the potential to develop into person-focused and caring pharmacy professionals. A small number of respondents wondered which skills and attributes could be tested by admission procedures and which ones could be developed over the course of initial education and training. They welcomed clarity on the matter.

4.15. Some respondents felt that because applicants were too young and might not be able to demonstrate the maturity and professional attitudes required of them, assessing applicants’ skills and attributes would not provide a good measure of their future abilities and were concerned that too stringent admission procedures would prevent applicants who could become successful pharmacists from entering onto MPharm degrees.

4.16. A small number of respondents were also concerned that assessing applicants’ skills and attributes would dissuade applicants as school leavers would choose to apply to other healthcare professions.

4.17. Several respondents pointed out that not every MPharm student will work in a patient-facing role, or become a practising pharmacist. They explained that some students may choose to work in industry or academia. These respondents questioned the need to assess the communication skills of applicants and did not want the selection process to eliminate applicants more suited to research for example.
Table 9: Views on making an interactive component mandatory in admission procedures

<table>
<thead>
<tr>
<th>Q9. Do you agree or disagree with our proposal to make an interactive component mandatory in integrated initial education and training admission procedures?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>250 (48%)</td>
<td>59 (58%)</td>
<td>309 (50%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>159 (31%)</td>
<td>25 (25%)</td>
<td>184 (30%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>43 (8%)</td>
<td>9 (9%)</td>
<td>52 (8%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>28 (5%)</td>
<td>6 (6%)</td>
<td>34 (5%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>25 (4%)</td>
<td>1 (&lt;1%)</td>
<td>26 (4%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>14 (3%)</td>
<td>2 (2%)</td>
<td>16 (3%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

4.18. As the above table indicates, 80% of consultation respondents agreed with our proposal to make an interactive component mandatory in admission requirements. The views of individual and organisational respondents were similar (79% and 83%). 9% of consultation respondents disagreed with that proposal.

4.19. Just under half of respondents provided open-ended comments to this question. Many respondents explained why interactive components should be incorporated in admission procedures, others made specific suggestions regarding their format. Several respondents also considered how interactive components could remain inclusive, while others mentioned the cost linked to the introduction of this proposal. The views of stakeholders, patients and members of the public who participated in our events is also represented in this section, as these were similar to the ones of survey respondents.

Informing applicants of what a career in pharmacy means

4.20. There was common agreement that admission procedures should also inform applicants about what pharmacy practice entails so they know what to expect from the profession. Some respondents explained, that in some cases, trainees only realise during their pre-registration placement that pharmacy is ‘not something for them’. In their opinion, providing applicants with that information during admission procedures would enable them to choose the right course for them.

Advantages of having interactive components in admission procedures

4.21. There was general agreement that including interactive components in admission procedures would ensure a better assessment of applicants as respondents felt that conducting interviews was essential to assessing applicants’ skills and attributes.

4.22. There was a common theme about the importance of assessing applicants holistically and not just on their academic performance. Other respondents mentioned that written applications do
not always truly reflect an applicant’s personality, values, skills and attributes. Many respondents who provided open-ended feedback agreed about the limitations of an admission process requiring applicants to describe their skills instead of demonstrating them. For them, skills and attributes can only be assessed through interviews, meetings, group activities or discussions.

4.23. Many respondents felt that the only way to assess the communication and personal skills of applicants was through an interactive assessment. Many also felt that interviews were an excellent mean of assessing the motivation of prospective students.

Assessment format

4.24. Many respondents commented on how applicants should be assessed. A large number of them were in favour of a collaborative approach. They proposed that schools should involve employers from all sectors of pharmacy, learning in practice supervisors, pharmacists, patients, carer groups and lay people in admission procedures. In their view, a joined-up approach would ensure that a full spectrum of views on an individual’s suitability for patient-facing practice is sought.

4.25. Several respondents made specific suggestions. They felt that admission procedures should take place in multiple settings, include a panel interview, group interviews, multi mini interviews (MMIs), a UK clinical aptitude test (UKCAT). A few respondents proposed to take the Biomedical admission test (BMAT) as an example.

4.26. Respondents were divided in regard to conducting face-to-face interviews. A small number of respondents did not think that conducting interviews over Skype was appropriate. They felt that some skills and attributes, for instance empathy, could only be assessed face-to-face. These respondents proposed that all applicants residing in the UK were interviewed face to face, even if they applied through Clearing. Schools, however, explained that there was little to no time to organise face to face interviews during Clearing. They proposed to conduct interviews using digital technologies or on the phone during that period. Some individual respondents and organisations also thought that one-to-one interviews over video were acceptable but, in their view, these should be justified by individual circumstances and should not become the norm.

4.27. A small number of respondents suggested that schools should consider remote selection centres as this would support equity of assessment and access. In general, respondents agreed there must be equitable mechanisms for selecting candidates irrespective of their route of entry. Ensuring consistency and equity were common themes across many consultation responses. It was also mentioned that admission procedures should be comparable across all schools and during Clearing in order to maintain high standards.

Ensuring admission procedures are inclusive

4.28. A large number of respondents were concerned that making an interactive component in admission procedures mandatory would disadvantage school leavers from less privileged backgrounds, from lower-performing schools or colleges, or sharing particular protected characteristics. Their main concern was that these school leavers might not have had the social and educational opportunities to develop their self-confidence, communication skills and group work and therefore would perform less well during an interactive assessment. Respondents expected schools to ensure that students from disadvantaged backgrounds are not overlooked.
because of inadequate support in preparing for the admission process. Some respondents questioned how shy individuals or applicants with social anxieties would be impacted by this proposal. Other respondents mentioned that some applicants from wealthy backgrounds can be coached for selection interviews which would play in their favour and felt this needed to be taken into consideration.

4.29. Some respondents also mentioned that interactive assessments, such as situational judgement tests and multiple mini interviews, could introduce further subjectivity and unconscious bias in admission procedures. They felt that strong safeguards against unconscious and conscious bias should be put in place to ensure the fairness and reliability of such processes. In that regard, many respondents welcomed the proposal for providers to analyse the admissions profile of applicants by protected characteristics. Others underlined the importance of adequate training for everyone involved in admission procedures.

4.30. A small number of respondents suggested that interactive assessments might enable applicants who failed to obtain required grades to be considered and show through their skills and motivation that they are worthy to be accepted onto an MPharm degree.

4.31. A small number of respondents mentioned that applicants did not all have the same access to technologies such as the internet. They suggested removing the references to specific technologies so as not to negatively impact any applicants.

Financial and resource implications

4.32. Many schools mentioned the cost linked to incorporating an interactive component into their admission procedures. In particular, they mentioned: the large number of applicants; the training they would have to deliver to their staff; the fact that some candidates apply outside the standard recruitment period (Clearing, international applicants); and that some interview strategies are resource-intensive. These respondents suggested schools would struggle to deliver this proposal without additional funding.

Table 10: Views on being more prescriptive about admission requirements

<table>
<thead>
<tr>
<th>Q10. To achieve this balance, should we be more prescriptive about admissions requirements? ²</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>301 (58%)</td>
<td>48 (47%)</td>
<td>349 (56%)</td>
</tr>
<tr>
<td>No</td>
<td>141 (27%)</td>
<td>30 (29%)</td>
<td>171 (28%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>77 (15%)</td>
<td>24 (24%)</td>
<td>101 (16%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

4.33. As Table 10 indicates, 56% of respondents felt that we should be more prescriptive about entry requirements. A larger proportion of individual respondents (58%) were in favour of more prescriptive entry requirements compared to organisational respondents (47%). A higher

² Consultation on initial education and training standards for pharmacists (pages 39 and 40)
proportion of organisations were unsure whether we should be more prescriptive (24%) compared with individuals (14%).

4.34. Almost two-thirds of respondents provided open-ended feedback to this proposal. Respondents had diverging views on setting more prescriptive admission requirements. Some respondents felt that minimum entry requirements should be set to ensure high standards are maintained and to be fairer to students. Other respondents felt that entry requirements should be left to schools and that some flexibility regarding required entry grades should be allowed. Many respondents also repeated their support for inclusive admission procedures. The views of consultation respondents also reflect what was heard in our stakeholder events, although fairness to applicants was particularly important to patients and members of the public.

Setting more prescriptive admission requirements

4.35. A common theme amongst respondents who provided open-ended comments was that more prescriptive admission requirements would maintain high academic standards and ensure the best applicants are selected. Many respondents underlined the difficulty of the MPharm degree, the high expectations placed on the profession and the fact that the NHS is planning to give pharmacists a leading role in the future. In their view, admission procedures should ensure the selection of students who would be able to meet these expectations.

4.36. A large number of respondents were of the view that only prescriptive admission requirements would reduce the number of students who are not able to complete the MPharm degree, their pre-registration placement or to pass the registration assessment. They felt that a more rigorous selection of applicants would be fairer to the students who are likely to struggle to meet the course’s expectations and would fail to register as a pharmacist. They explained that students invest considerable resource and time in their education and training and accepting applicants with lower grades than the required grades would potentially disadvantage them from the outset.

4.37. Several respondents proposed that we should set minimum entry grades (in general or for specific scientific subjects) to ensure consistency between the different schools. In their view, the differing standards of the schools in regard to entry requirements were of concern and only applicants meeting the academic criteria should be accepted. Patients and members of the public considered that more consistency would reinforce public confidence in the aptitude and proficiency of new pharmacists. A small number of respondents also mentioned the performance pressures universities are under and felt that in that climate, it was important for us to set specific minimum requirements. The respondents who asked for minimum entry grades encouraged us to engage with schools to ascertain what admission requirements were appropriate.

4.38. Some respondents were of the opinion that schools should not be allowed to admit onto their MPharm degrees applicants who did not meet their academic entry requirements to ensure the integrity of the profession. Other respondents felt that a degree of flexibility could be allowed and that schools could accept a small number of applicants who did not meet their entry grades. However, in their view, schools should be held accountable and, when accepting applicants with low academic achievement, explain their decisions.
4.39. Other suggestions included the GPhC specifying which A-level subjects should be considered by schools and specifying a maximum percentage of places allocated to applicants with lower grades.

4.40. A few respondents were concerned about the number of applicants getting into pharmacy through Clearing. They proposed that only applicants who met the required grades should be accepted onto MPharm degrees, or to limit their number (for example set percentage for each school).

Not only focusing on academic requirements

4.41. A large number of respondents explained that some school leavers do not achieve the minimum entry requirements but still have the academic ability, skills and attitudes to make good pharmacists. It was therefore for them that admission procedures do not only focus on applicants’ grades. According to them, assessing an applicant’s potential, personality, attitude to learning, attention to detail, communication skills, and empathy was as important. In their view, pharmacy was much more than academic excellence and only taking into consideration academic achievement was misguided.

4.42. Other respondents suggested that, schools should be given the flexibility to make judgements, taking into account applicants’ personal and social circumstances, as well as their skills and attributes, in cases where they have missed the entry requirements by a few grades. These respondents felt that, as long as there were clear documented reasons for accepting students who did not meet the academic criteria, schools should be able to accept them.

GPhC involvement in admission requirements

4.43. Other respondents, mainly schools of pharmacy, were of the opinion that entry requirements (including the possibility to accept unconditional offers) should be left to schools. In their view, the regulator should only provide guidelines and allow schools to set their own admissions standards as much as possible. They explained that schools have quality assurance procedures that prevent students who are unable to progress from moving one year to the next. These respondents were also of the view that the emphasis should be placed on developing academic performance and supporting students to achieve their potential. For them, admission procedures should not prevent the admission of students who, with support, may be able to complete the programme. Several respondents explained that this approach was especially important for applicants with historically low participation in higher education.

4.44. A number of respondents mentioned that each school has its own approach to teaching and that students flourish in different environments. In their opinion, some schools were better than others in supporting students who have entered with lower grades. They therefore argued that entry requirements should not be the same for all schools and proposed that schools track the performance of their MPharm students according to their entrance qualifications and grades and to review their admission criteria based on that evidence.

4.45. Several respondents were concerned that more prescriptive admission requirements would lead to some schools not being able to recruit to their target numbers and having to close. They explained that admissions criteria vary depending on supply and demand and that more restrictive requirements would interfere with the functioning of this market.
4.46. A small number of respondents were concerned that setting more prescriptive entry requirements would prevent schools from accepting applicants with equivalent qualifications (for example foundation degrees, access diploma and overseas qualifications) or relevant experience (for example pharmacy technicians, mature students).

Evidence base supporting the proposed changes

4.47. Several schools asked what evidence base was used in drafting the consultation proposals in relation to admissions. Some questioned the fact that solely assessing the past academic achievements of applicants was not sufficient in predicting students’ future academic success. Others asked about the registration assessment success rate of students who entered the MPharm degree via Clearing or had been made an unconditional offer. These respondents felt that a careful analysis focusing on the link between admissions and registration assessment success should be undertaken. They believed this research should be undertaken before setting more prescriptive requirements.

Ensuring admission procedures are inclusive

4.48. There was a common theme about the importance of ensuring a balance between maintaining high admission standards and widening access. For them, allowing school leavers into the profession who previously may not have considered becoming a pharmacist, would enhance the attributes of the profession.

4.49. Many respondents were concerned that school leavers from lower socio-economic backgrounds, who may not have realised their full potential at A-levels, would be negatively impacted by stricter requirements. For them, it was important for schools to be able to make exceptions or apply alternative standards to applicants based on schooling, background or other circumstances. Respondents suggested that the groups of people who would fall into these categories should be identified and distinguished from applicants who are clearly unsuitable for the course. For example, they proposed slightly lower academic criteria to be applied to the candidates scoring particularly well in the interactive components of admission procedures.

Table 11: Views on disallowing unconditional offers

<table>
<thead>
<tr>
<th>Q11. Should we continue to allow unconditional offers?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>113 (22%)</td>
<td>17 (17%)</td>
<td>130 (21%)</td>
</tr>
<tr>
<td>No</td>
<td>334 (64%)</td>
<td>59 (58%)</td>
<td>393 (63%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>72 (14%)</td>
<td>26 (25%)</td>
<td>98 (16%)</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>519 (100%)</strong></td>
<td><strong>102 (100%)</strong></td>
<td><strong>621 (100%)</strong></td>
</tr>
</tbody>
</table>

4.50. Table 11 shows that 63% of consultation respondents were of the opinion that unconditional offers should not be allowed. The proportion of individual respondents who felt that unconditional offers should not be allowed (64%) was marginally larger compared to that of
organisational respondents (58%). A higher proportion of organisations were unsure whether we should continue to allow unconditional offers (25%) compared with individuals (14%).

4.51. Just over half of survey respondents provided open-ended feedback to this question. Many of these respondents felt that unconditional offers should not be allowed – a position shared by the patients and members of the public who participated in consultation events. Others were in favour of a more flexible approach.

Views on unconditional offers

4.52. Respondents made a distinction between different types of unconditional offers. Most of them felt that offering unconditional offers to students, who met entry requirements, but deferred joining the programme (for example because of a gap year) was appropriate. Scottish respondents explained that, in Scotland, unconditional offers are made only after attainment of the desired grades.

4.53. There was broad agreement that unconditional offers were not appropriate for a professional degree as many respondents thought that unconditional offers undermined public confidence in pharmacists and sent the wrong message to the profession. They expected practising pharmacists to meet high standards at all times and to commit to life-long learning. For them, these two elements should be mirrored in admission procedures and applicants should be able to demonstrate they maintained a high work ethic throughout their school years. Many respondents thought that unconditional offers did not encourage excellence and were detrimental to raising the standards of education and training.

4.54. Several respondents were of the view that MPharm places should be awarded on merit, and not on predicted achievement. They did not want pupils to lose the incentive to prepare for their A-levels and not study to their academic ability. Several respondents felt that the inadequate preparation of pupils for their A-levels might lead to school leavers not being adequately prepared for an intensive university course such as the MPharm degree. For them, the A-levels were not an end in themselves but provide the knowledge needed for the pharmacy course.

4.55. Other respondents considered that unconditional offers were not transparent or fair to other students who worked hard for their A-Levels.

4.56. A few respondents pointed out that introducing an interactive component in admission procedures would be incompatible with allowing unconditional offers, when they are granted without interviews.

Flexibility with grades

4.57. Other respondents, mainly schools of pharmacy and a few individual respondents, thought that some flexibility in regard to academic achievements required for entry onto an MPharm degree should be allowed. In their opinion, some applicants still have the capacity to complete an MPharm degree even if they missed the required grades by a few marks. Suggestions included: comparing applicants’ academic results to other entry requirements, applicants’ motivation and aptitude to learn, and taking into consideration the personal circumstances that might have led to poorer academic performance.

4.58. A few patients and members of the public suggested allowing unconditional offers while controlling their number. They suggested setting a maximum percentage for all schools.
5. Experiential learning and inter-professional learning

Table 12: Views on our proposals in regard to experiential learning and inter-professional learning

<table>
<thead>
<tr>
<th>Q12. Do you agree or disagree with our proposals in regard to:</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>297 (57%)</td>
<td>59 (58%)</td>
<td>356 (57%)</td>
<td>290 (56%)</td>
<td>57 (56%)</td>
<td>347 (56%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>149 (29%)</td>
<td>32 (31%)</td>
<td>181 (29%)</td>
<td>159 (31%)</td>
<td>32 (31%)</td>
<td>191 (31%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>31 (6%)</td>
<td>3 (3%)</td>
<td>34 (5%)</td>
<td>31 (6%)</td>
<td>2 (2%)</td>
<td>33 (5%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>18 (3%)</td>
<td>4 (4%)</td>
<td>22 (4%)</td>
<td>17 (3%)</td>
<td>7 (7%)</td>
<td>24 (4%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>13 (3%)</td>
<td>2 (2%)</td>
<td>15 (2%)</td>
<td>13 (3%)</td>
<td>2 (2%)</td>
<td>15 (2%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>11 (2%)</td>
<td>2 (2%)</td>
<td>13 (2%)</td>
<td>9 (2%)</td>
<td>2 (2%)</td>
<td>11 (2%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

5.1. As reflected in the figures in Table 12 above, 86% and 87% of consultation respondents agreed with our proposals in regard to experiential learning and inter-professional learning respectively. The views of individual and organisational respondents were similar (86% and 89%). 6% of all consultation respondents disagreed with each of the proposals.

5.2. Just over half of consultation respondents provided open-ended feedback to these proposals. A large number of them welcomed our proposed changes, with many mentioning the current variations in the delivery of these two components. Some respondents made suggestions in regard to implementing our proposed changes.

Benefits of experiential learning and inter-professional learning

5.3. There was general approval for an increase of experiential and inter-professional learning as this would enable students to improve the standards of practice of pharmacists.

5.4. There was broad agreement that, as the pharmacist role becomes more clinical, it was important that students are exposed to patients and real-life situations as early in their training as possible. Many respondents felt that pharmacists needed to have experience of working with patients before going into practice, to be able to better communicate with them and to improve their consultation and diagnostic skills.

5.5. Many respondents were of the view that more experiential learning would better prepare students for the workplace environment. They felt that experiential learning was essential for
Analysis report on the consultation on initial education and training for pharmacists

5.6. A large number of respondents also explained that pharmacists are increasingly working as part of multi-disciplinary teams. Respondents felt that increased communication skills would enable pharmacists to practice to a high clinical level and as part of clinical teams. For many respondents, inter-professional learning should be incorporated in MPharm degrees from the start so that students can forge working partnerships and awareness of roles and responsibilities at the earliest possible stage.

5.7. Several schools mentioned they were already offering more experiential and inter-professional learning in their programmes and that students found these two components beneficial.

Current variation in delivery

5.8. Some respondents felt that our proposals in regard to experiential learning should go further. They were of the opinion that the amount of experiential learning should be standardised. Training providers especially explained that they had noticed some important differences in pre-registration trainees’ competences depending on how much experiential learning their MPharm degree entailed. In their experience, students who had benefited from more experiential learning tended to be able to ‘get on’ with their pre-registration placement much more easily. Other respondents observed that, currently, students had limited direct and simulated patient exposure. For instance, several pharmacists explained that they did not properly carry out a consultation or a drug history with a ‘real’ patient before their pre-registration training. Several respondents pointed out that other healthcare students spent much more time in the workplace than student pharmacists.

5.9. Similarly, many respondents explained that, as inter-professional learning was not formalised, there was a lot of variation in the delivery of inter-professional learning. A large number of respondents mentioned that some students do not get to meet with other health and care professionals, and this results in students not always being confident when interacting with colleagues. They felt it was essential to embed inter-professional learning best practice throughout the five years of initial education and training to ensure more consistency between providers and that all students are appropriately prepared for their future practice. For them, increasing exposure to other professional groups and introducing multi-sector training much earlier in the MPharm degree would build students’ resilience to challenging transitions.

Learning needs

5.10. Many respondents agreed that students needed insight into the different roles of pharmacists from the start of their training, so they are later able to relate to patients and provide high quality care. They suggested that students should be exposed to a range of patients in a variety of environments, so they learn how to deal with different kinds of patients with different, and at times complex, needs. It was important to some respondents that students developed their communication skills in a wide variety of real-life situations and not just in simulated settings.

5.11. Many respondents felt that inter-professional learning would enable students to learn how to interact with different health and care professionals to be able to deliver higher standards of care and to work as an active member of the multi-disciplinary team. There was broad agreement that pharmacists needed to know how their role fits in the multi-disciplinary team.
and to understand the strengths and limitations of other professions. Several respondents pointed out that inter-professional learning would also enable other professions to better understand the role of pharmacists, which would be beneficial for building stronger working relationships with them in the future.

Delivering experiential learning

5.12. Many respondents made specific suggestions or required clarifications on how to implement experiential learning and inter-professional learning.

Experiential learning

5.13. Several respondents were of the opinion that experiential learning should be introduced in MPharm degrees from day one, that activities should be meaningful, and that students should be appropriately supported. Respondents emphasised that students should not only observe but also participate at a level which was appropriate to their competency.

5.14. Other respondents asked for minimum acceptable requirements. They wondered what was the minimum amount of experiential learning that should be incorporated in MPharm degrees. It was, in their view, important to set a minimum requirement to ensure consistency between schools.

5.15. A small number of respondents thought that students should have a minimum amount of clinical knowledge before being exposed to certain situations. For them, experiential learning should take place at a point which was both clinically appropriate and safe for students to have interactions with patients and other healthcare professionals.

5.16. Several respondents suggested that schools should work with training providers to ensure sessions are tailored to students’ learning needs. They favoured a collaborative approach to develop models which would work for all parties and across multiple sectors.

5.17. A few respondents felt that students should be exposed to several sectors of pharmacy practice and rotate between hospital, community, GP settings, laboratory, industry settings, etc. A small number of respondents indicated that students should also have contact with non-clinical individuals working in healthcare (for example service managers and commissioners).

Inter-professional learning

5.18. Respondents, mainly schools, required more clarification on the amount and frequency of inter-professional learning.

5.19. There was a number of specific suggestions in regard to how inter-professional learning should be delivered. Several respondents felt that it should be mandatory, and similarly to experiential learning start as early as the first year of the MPharm degree, should take place in a few different training sites and regularly throughout all stages of the education and training pathway. Other respondents were of the view not to limit students’ exposure to dentists, nurses and doctors.

5.20. As for experiential learning, some respondents wanted the regulator to set a minimum requirement for inter-professional learning. However, others pointed out that the quality of inter-professional learning was more important than its frequency.
5.21. There were also a few requests for guidance on how schools and training providers should work together. Respondents were unsure about how schools should monitor inter-professional learning and ensure the quality of assessment in different placement sites.

**Challenges linked to the delivery of our proposals**

5.22. Many responses underlined the potential cost of our proposals. Schools explained that they would need further funding to be able to successfully implement both experiential and inter-professional learning. They also pointed out significant resource and logistic costs.

5.23. In regard to experiential learning, respondents explained that shorter and more frequent placements would need to be coordinated alongside longer periods of learning in practice. Schools explained that any increases beyond current provisions would require more funding. They anticipated they would need to recruit staff, involve expert patients and increase their administrative resources.

5.24. In regard to inter-professional learning, respondents mentioned that, contrary to other professions, additional funding was not available to schools of pharmacy in all of the UK countries to deliver inter-professional learning. They explained that schools currently did as much as they could afford. For them, funding was currently restricting the further expansion of inter-professional learning. Several respondents also mentioned that it was sometimes difficult to organise inter-professional learning with other professions as they had different education and training models. They proposed for us to work with the regulators of these professions to ensure that the emphasis on inter-professional learning was achievable.

### 6. Learning in practice (pre-registration) supervision

**Table 13:** Views on replacing the current four tutor sign-offs with more regular progress meetings between learning in practice supervisors and student pharmacists

<table>
<thead>
<tr>
<th>Q13. Do you agree or disagree with our proposal to replace the current four tutor sign-offs with more regular progress meetings between learning in practice supervisors and student pharmacists?</th>
<th>N and %</th>
<th>N and %</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>225 (43%)</td>
<td>35 (34%)</td>
<td>260 (42%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>153 (29%)</td>
<td>44 (43%)</td>
<td>197 (32%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>54 (10%)</td>
<td>10 (10%)</td>
<td>64 (10%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>43 (8%)</td>
<td>7 (7%)</td>
<td>50 (8%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>16 (3%)</td>
<td>1 (&lt;1%)</td>
<td>17 (3%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>28 (5%)</td>
<td>5 (5%)</td>
<td>33 (5%)</td>
</tr>
</tbody>
</table>

Total N of responses | 519 (100%) | 102 (100%) | 621 (100%) |
6.1. As indicated in table 13, 74% of respondents agreed with our proposal to replace the current four tutor sign-offs with more regular progress meetings between learning in practice supervisors and student pharmacists. Proportionally, slightly more organisational respondents (77%) agreed with our proposal compared with individual respondents (72%). 11% disagreed with the proposal and 5% were unsure with these findings being similar across organisations and individuals.

6.2. Just over half of respondents provided open-ended feedback to that question. The most common response provided was that more regular progress meetings would better support students’ progression. Respondents also made specific suggestions in regard to meetings’ frequency, training and support of supervisors, ensuring continuity in the supervision of students and quality assurance. Concerns about resources available to organise regular progress meetings were also raised. The same views to the ones captured in this section were raised during our stakeholder consultation events.

Benefits of regular progress meetings

6.3. Many responses pointed out that there are significant variations in the quality of pre-registration supervision both between and within sectors. Some respondents indicated that the engagement of pre-registration tutors with trainees could sometimes be insufficient. They explained that trainees could sometimes be considered as ‘an extra pair of hands’ and that they did not always receive regular feedback.

6.4. A common theme amongst respondents who provided feedback was that regular progress meetings would ensure that students could progress more consistently and continuously towards the learning outcomes. In their view, it was important for students to regularly meet their supervisors to ensure they were progressing with their learning, coping with their workload and could discuss professional issues on a regular basis. For many respondents, replacing the current four tutor sign-offs with more regular progress meetings would strengthen the quality of training.

6.5. There was common agreement that regular meetings would enable supervisors to have a better overview of a student’s development. Respondents agreed that supervisors would have a better idea of how students were getting on with their learning, what their learning needs were, and would be able to support students sooner.

6.6. Respondents also welcomed a more tailored approach to students’ supervision. In their view, more regular discussion of students’ learning needs would give both supervisors and students an opportunity to adjust training plans more flexibly, enable students to develop faster and reduce the risk of any issue becoming a long-standing problem. For respondents, a more regular assessment of students’ progress would also allow supervisors to enable willing and competent students to progress faster.

Frequency of the progress meetings

6.7. Many respondents felt that the frequency of meetings should depend on the learning needs of students. For them, assessing and giving feedback to students should be dynamic and reactive. Other respondents asked for a minimum number of progress meetings to ensure consistency between training providers. They explained that some supervisors have a heavy workload and wanted to make sure at least a minimum number of meetings between supervisors and students took place. They were of the opinion that, if a clear standard did not replace the four
tutor sign-offs, there was a risk that contacts between students and supervisors would decrease.

**Supervisors’ training and support**

6.8. A common theme was that the training of supervisors should be improved. Many respondents felt that supervisors should be appropriately trained and should benefit from ongoing support with mentoring and providing constructive feedback to students. In their view, adequate training should be provided to supervisors, so they have a clear understanding of what is expected of them and of students. For these respondents, regular progress meetings will only be successful if supervisors are supported to carry out their role as the quality of the meetings is dependent on the skills of the practice supervisor.

**Supervision continuity**

6.9. A number of respondents mentioned that several shorter learning in practice placements over different training sites might mean that the continuity of supervision and development of the student by one or two supervisors would be lost. They were worried that supervisors would lose the overview of the strengths and weaknesses of students and the responsibility for their full training. They were also concerned that shorter placements would make signing students’ competencies more difficult.

6.10. Many respondents underlined that communication between the different supervisors would be crucial to ensure students’ appropriate development. Several respondents mentioned that records of students’ progress, for instance portfolios or electronic records, should be passed on from supervisor to supervisor. Some respondents were in favour of digital technology as they found the ability to upload evidence and record meetings on an online platform to be a more efficient use of time for both supervisors and students. A few respondents agreed that e-portfolios could be used as a two-way feedback stream between supervisors and students and reflect students’ journeys.

**Quality assurance of learning in practice supervision**

6.11. Many respondents were unsure about how regular progress meetings should take place in practice. They asked about the remit and structure of the meetings, their organisation and how frequently they should take place. They also asked about the relationship between schools and training providers and questioned quality assurance mechanisms.

6.12. Several respondents pointed out that increasing the number of meetings between supervisors and students was not enough. They explained that having regular meetings would not necessarily improve the quality of the feedback provided to students. They were concerned that regular meetings could also be considered by certain supervisors as a ‘tick box’ exercise. For them, what was more important to tackle was the quality of the supervision to ensure students meet the learning outcomes. These respondents felt that learning in practice supervision needed to be adequately governed and monitored.

6.13. There were a few diverging views in regard to how schools should be involved in the progress meetings. Some respondents proposed that schools’ representatives participated in some of the progress meetings as schools would need to have oversight of the whole learning journey. Others suggested that schools or the GPhC should quality assure students’ portfolios to ensure students are supported to meet the learning outcomes. For some respondents, it was essential
for schools to quality assure the progress of students and to review the progression reports submitted after each period of learning in practice. A few respondents asked whether and how the GPhC would be involved in quality assuring the learning in practice supervision. Respondents agreed learning in practice supervision needed greater quality control and assurance mechanism built in. Other respondents were concerned that schools would not have the resources to put that in place. For them, quality assuring regular progress meetings would be difficult for schools to organise within the existing funding available. Many consultation responses asked for clarification regarding schools’ responsibilities and oversight of learning in practice.

Financial and resource implications

6.14. Even though a significant number of respondents agreed on the importance of having regular informal dialogue between supervisors and students, some respondents disagreed with replacing the current four tutor sign-offs with more regular progress meetings. These respondents were concerned about the impact of this proposal on the workload of the teams providing placements. They explained that some supervisors already struggle to balance their clinical workload with their supervising role and that mandating an increased number of supervision meetings could be difficult for them to achieve. Several respondents were also concerned about supplementary paperwork, as they thought it could take pharmacists further away from doing their job. These respondents mentioned the increasing work-pressures placed on practising pharmacists and were concerned that training sites may be less keen to accept students if supervision activities took pharmacists away from their day-to-day work.

6.15. Several respondents also expressed concerns about the resources and funding available to undertake regular progress meetings. They pointed out that some training providers may not have enough resources to cope with the time required to perform regular progress meetings. They explained that the workforce is already stretched and might struggle to support candidates who do not meet the learning outcomes. These respondents thought that organising more regular progress meetings would only be viable with additional resources. They asked to be supported by appropriate funding models within the employment sectors. In their view, an appropriately funded support structure would need to cover supervisors’ training and the quality assurance of placements.
Table 14: Views on replacing the current pre-registration performance standards with the learning outcomes

<table>
<thead>
<tr>
<th>Q14. Do you agree or disagree with our proposal to replace the current pre-registration performance standards with the learning outcomes stated in Part 1 of the revised standards?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>204 (39%)</td>
<td>46 (45%)</td>
<td>250 (40%)</td>
</tr>
<tr>
<td>Tend to agree</td>
<td>183 (35%)</td>
<td>33 (32%)</td>
<td>216 (35%)</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>64 (12%)</td>
<td>9 (9%)</td>
<td>73 (12%)</td>
</tr>
<tr>
<td>Tend to disagree</td>
<td>17 (3%)</td>
<td>6 (6%)</td>
<td>23 (4%)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>16 (3%)</td>
<td>3 (3%)</td>
<td>19 (3%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>35 (7%)</td>
<td>5 (5%)</td>
<td>40 (6%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

6.16. As presented in Table 14, 74% of respondents agreed with our proposal to replace the current pre-registration performance standards with the learning outcomes stated in Part 1 of the standards. A slightly larger proportion of organisations (77%) agreed with this proposal, compared to individual respondents (72%).

6.17. Just under half of consultation respondents provided open-ended feedback to this proposal. There was general support for replacing the performance standards by the learning outcomes, although some respondents asked for guidance on how to implement this change.

Replacing the performance standards with learning outcomes

6.18. There was broad agreement that the current performance standards used to assess pre-registration trainees’ progression needed to be updated in order to be relevant to current practice. Respondents also mentioned that the current performance standards were repetitive and sometimes viewed as a tick box exercise.

6.19. Several respondents agreed that students’ progression in an integrated degree should be measured by a single, coherent set of learning outcomes covering both theoretical and practical learning. From an educative perspective, respondents were also of the opinion that having one set of integrated learning outcomes made sense as it was clearer for all stakeholders involved in the initial education and training of pharmacists.

Guidance to support the use of the learning outcomes during learning in practice

6.20. Many respondents questioned how the learning outcomes should be implemented. They were unsure about how specific competencies should be demonstrated and assessed as they thought that the learning outcomes were too open to interpretation. Respondents also felt that replacing the performance standards by the learning outcomes was a significant change and that successful implementation required a high level of rigour, support and guidance. Indeed,
some respondents suggested that replacing the performance standards by the learning outcomes without providing guidance could lead to variability and inconsistencies. Many respondents felt that an evidence framework providing guidance on how to implement the standards and the learning outcomes should be developed as specific examples would benefit the implementation of learning in practice.

6.21. A small number of respondents asked for guidance on when specific learning outcomes should be demonstrated and assessed.

Retaining the performance standards

6.22. A smaller number of respondents thought that the existing performance standards were valuable to both students and those supporting or assessing learning in practice. Some of them also mentioned that the performance standards provided clarity to students on what was expected of them. These respondents were of the opinion that the performance standards should be retained and updated instead of being replaced. A few respondents also preferred the performance standards as they found the learning outcomes too vague.

6.23. A few respondents were concerned that a single set of learning outcomes to be achieved over the five years of initial education and training would not provide sufficient specificity to accommodate the range of models of initial education and training.
7. The impact of the proposed changes on people sharing particular protected characteristics

Table 15: Views on our proposals benefiting any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

<table>
<thead>
<tr>
<th>Q15. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>46 (9%)</td>
<td>4 (4%)</td>
<td>50 (8%)</td>
</tr>
<tr>
<td>Disability</td>
<td>37 (7%)</td>
<td>6 (6%)</td>
<td>43 (7%)</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>30 (6%)</td>
<td>6 (6%)</td>
<td>36 (6%)</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>23 (4%)</td>
<td>2 (2%)</td>
<td>25 (4%)</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>27 (5%)</td>
<td>6 (6%)</td>
<td>33 (5%)</td>
</tr>
<tr>
<td>Race</td>
<td>33 (6%)</td>
<td>6 (6%)</td>
<td>39 (6%)</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>25 (5%)</td>
<td>5 (5%)</td>
<td>30 (5%)</td>
</tr>
<tr>
<td>Sex</td>
<td>24 (5%)</td>
<td>4 (4%)</td>
<td>28 (5%)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>27 (5%)</td>
<td>5 (5%)</td>
<td>32 (5%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>445 (86%)</td>
<td>90 (88%)</td>
<td>535 (86%)</td>
</tr>
</tbody>
</table>

7.1. As Table 15 shows, 86% of survey respondents did not think our proposals would benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Those who thought our proposals would benefit people sharing particular protected characteristics most commonly selected age (8%), disability (7%), race (6%) and gender reassignment (6%).

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3 Respondents were asked to tick all that applied.
Table 16: Views on our proposals discriminating or unintentionally disadvantaging any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

<table>
<thead>
<tr>
<th>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?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>51 (10%)</td>
<td>23 (23%)</td>
<td>74 (12%)</td>
</tr>
<tr>
<td>Disability</td>
<td>63 (12%)</td>
<td>24 (24%)</td>
<td>87 (14%)</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>14 (3%)</td>
<td>5 (5%)</td>
<td>19 (3%)</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>18 (3%)</td>
<td>15 (15%)</td>
<td>33 (5%)</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>47 (9%)</td>
<td>24 (24%)</td>
<td>71 (11%)</td>
</tr>
<tr>
<td>Race</td>
<td>39 (8%)</td>
<td>25 (25%)</td>
<td>64 (10%)</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>21 (4%)</td>
<td>12 (12%)</td>
<td>33 (5%)</td>
</tr>
<tr>
<td>Sex</td>
<td>22 (4%)</td>
<td>6 (6%)</td>
<td>28 (5%)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>13 (3%)</td>
<td>6 (6%)</td>
<td>19 (3%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>405 (78%)</td>
<td>63 (62%)</td>
<td>468 (75%)</td>
</tr>
</tbody>
</table>

7.2. As Table 16 shows, 75% of survey respondents 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. Those who thought our proposals would negatively impact people sharing particular protected characteristics selected disability (14%), age (12%), pregnancy and maternity (11%) and race (10%) more often than the other protected characteristics.

7.3. Just over half of consultation respondents provided open-ended feedback on whether our proposed changes for the initial education and training of pharmacists would positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. The views presented below are also representative of event participants.

Age

7.4. Many of the respondents who provided feedback were concerned about the impact of our proposals on mature students.

7.5. In regard to selection and admission, respondents were worried that prescriptive academic requirements may adversely impact mature students who did not achieve the required grades at A-level or had atypical qualifications. For them, raising MPharm entry academic requirements could potentially reduce the number of mature students who choose to study for

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4 Respondents were asked to tick all that applied.
an MPharm. Other respondents, however, pointed out that assessing applicants’ skills and attributes would take into consideration the experience, knowledge and skills mature students have acquired and could benefit them.

7.6. In regard to our proposal to integrate academic and practical learning, some respondents were concerned that mature students might no longer consider studying for an MPharm degree if they had to self-finance a fifth year of education and training. They explained that mature students often have other monetary obligations such as paying a mortgage or supporting their family. Some respondents also mentioned that mature students are more likely to have caring responsibilities and so might be less able to alternate between periods of learning at the university with periods of learning in practice. In that regard, respondents thought that mature students would be more affected by routine changes and less able to relocate for their learning in practice.

7.7. A large number of respondents felt that our proposals could negatively affect young people. Their concerns focused on the assessment of applicants’ skills and attributes during admission procedures. These respondents felt that young applicants might find it difficult to display professional attitudes and would struggle to demonstrate that they have the potential to be a professional pharmacist at the age of 17, 18 or 19.

Disability

7.8. A number of respondents felt that individuals with particular difficulties in communicating (for example people with autism spectrum disorders) might be negatively impacted by our proposal to assess the skills and attributes of applicants during admission procedures. They felt that if a disability made an individual less able to communicate or show empathy with others it would make it difficult for them to achieve a successful application. Other respondents believed that disabled people generally had lower grades and that setting more prescriptive academic requirements would have an impact on them joining MPharm degrees.

7.9. A few respondents were concerned that some individuals with disabilities might not be able to meet the learning outcomes because of serious health problems (for example severe visual impairments) or being less able to communicate and to show empathy. For instance, respondents felt that people with disabilities may be physically or mentally unable to help or respond in stressful situations and deliver first aid.

7.10. Several respondents were concerned about the support provided to disabled students while in learning in practice. They explained that the support provided by universities was usually better than training providers. They worried that, in an integrated degree, this lack of support from training providers might negatively impact students who also need reasonable adjustments during their training. For them, there should be early consideration of how adjustments should be organised for students during their periods of learning in practice. In their view, a greater degree of planning around placements should be undertaken to enable training providers to organise the appropriate reasonable adjustments for students with disabilities. A few respondents also indicated that disabled people may need placements closer to home, with a car park or with a wheelchair access.

7.11. Several respondents indicated that having to undertake several shorter learning in practice placements in different organisations might negatively impact students who have physical disabilities as they could find constant relocations challenging. Others mentioned that disabled...
people could be put off by having to regularly communicate their needs for reasonable adjustments to training providers. Other respondents thought that disabled students might be negatively impacted if they were no longer able to undertake their learning in practice part-time. They explained that there are significant differences in the physical and mental demands of full-time education and full-time work.

7.12. A few respondents wondered whether integrated learning would support or hinder neurodiverse students (for example students with dyslexia, or ADHD) and students with mental health problems. A small number of respondents proposed that, if done well, integrating learning may support students who prefer ‘action-based learning’. However, others mentioned that integrated learning may equally pose challenges to this student group, especially when splitting the existing pre-registration year to a range of clinical settings (community pharmacy, hospital and GP surgeries). For them, this would be unsettling for some students and not give them enough time to gain a deeper appreciation of a clinical setting which interests them and/or supports their learning style.

Marriage and civil partnership

7.13. Many respondents were of the view that students who are married, pregnant or who have caring responsibilities may need placements close to home. They were concerned that organising several shorter learning in practice placements would make it more difficult for these groups. For instance, they explained that people with children are likely to find it more difficult, if not impossible, to relocate during their learning in practice. Respondents also mentioned that part-time provisions needed to be organised for students with dependents.

Pregnancy and parental leave

7.14. Respondents had diverging views on the impact of our proposals on pregnancy and parental leave. Some respondents felt that students who are pregnant or on parental leave may be disadvantaged as it might be more difficult for them to temporarily pause their education or training in an integrated programme, or because they will be less flexible to relocate for their placements. These respondents thought that the management of a 5-year course should take into consideration that some students will need to take parental leave. Other respondents were of the opinion that having the opportunity to complete learning in practice over a period of five years would benefit anyone requiring parental leave, as they would not be under the same pressure to postpone the pre-registration year in one go. These respondents proposed that students should be able to ‘bank’ their competencies until they return from parental leave.

Race

7.15. Many respondents were concerned that Black, Asian and Minority Ethnic (BAME) groups and non-British applicants may be disadvantaged during admission procedures. They explained that, if bias was not monitored and controlled during the selection process, these applicants might be negatively impacted by cultural differences. For them, interactive recruitment methods could lead to introducing subjectivity and biases which could negatively impact specific groups if not managed carefully. Several respondents advised that all staff involved in admissions procedures should undertake rigorous cultural training to offset the chance of any unintentional discrimination.

7.16. Several respondents also mentioned that race is strongly linked to socio-economic status and education. They explained that a disproportionately large number of BAME people live in
poverty in the UK. For them, increasing the cost of pharmacy education and training would deter BAME applicants. Other respondents mentioned that raising the academic requirements for entry onto an MPharm degree may negatively impact BAME applicants. Some respondents proposed that all schools of pharmacy should have a minimum intake number for BAME students.

7.17. Several respondents mentioned that international students who wish to obtain a UK MPharm degree, but not undertake their learning in practice in the UK, might be disadvantaged by the integration of academic and practical learning as this might no longer be an option for them. Others pointed out that English was not the first language of all applicants and students. They were concerned that overseas applicants might be negatively impacted by admission procedures and might struggle with the learning outcomes focusing on communication. However, several respondents were of the opinion that overseas students would significantly improve their English while on the MPharm degree.

Religion or belief

7.18. A few respondents explained that some religious people may be reluctant to travel. In their view, if students were able to choose their training site, this group would not be negatively impacted by our proposals. These respondents felt that random allocation of placements could therefore be an issue for some religious individuals.

Sexual orientation

7.19. Several respondents felt that Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning (LGBTIQ) people are more likely to face a range of negative health experiences and can suffer from mental health problems. They mentioned that previous negative experiences in healthcare settings can prevent patients from disclosing relevant information about their sexual orientation or gender identity. They mentioned that the increased focus on person-centred care and improved communication in the standards would benefit LGBTIQ people.

8. Other impacts

Table 17: Views our proposed changes positively or negatively impacted any other individuals or groups

<table>
<thead>
<tr>
<th>Q17. Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups?</th>
<th>N and % individuals</th>
<th>N and % organisations</th>
<th>Total N and %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>313 (60%)</td>
<td>84 (82%)</td>
<td>397 (64%)</td>
</tr>
<tr>
<td>No</td>
<td>79 (15%)</td>
<td>5 (5%)</td>
<td>84 (14%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>127 (24%)</td>
<td>13 (13%)</td>
<td>140 (23%)</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>519 (100%)</td>
<td>102 (100%)</td>
<td>621 (100%)</td>
</tr>
</tbody>
</table>

8.1. As Table 17 indicates, 64% of respondents thought that our proposed changes would positively or negatively impact other individuals or groups. A larger proportion of individuals did not know whether the changes would impact others (24%) compared with organisations (13%). Event respondents shared similar views.
Positive impacts

On students and future pharmacists

8.2. Many respondents felt that our proposed changes would be beneficial for the development of students. In their opinion, the improved selection of students would ensure that more motivated and suitable students enter MPharm degrees. They also felt that students would be able to have an understanding of the profession and be able to decide if they wanted to become a pharmacist earlier. Others considered that learning in practice would be fairer and more consistent.

8.3. A large number of respondents felt that our proposals would increase the quality of the practice of future pharmacists because their knowledge of patients would be greater, their confidence and communication skills improved, pharmacists would be more professional, clinically competent and willing to lead, make decisions and take initiatives.

8.4. A few respondents felt that the new learning outcomes might make other professions change their perception of the skills of pharmacists. Some respondents pointed out that, due to inter-professional learning, other professions would benefit from pharmacists’ better understanding of their roles.

On patients

8.5. Many respondents were of the view that our proposed changes would be beneficial for patients as they would receive a higher standard of care.

On schools of pharmacy and training providers

8.6. Several respondents were of the view that the understanding of pharmacy practice of academic staff would be strengthened as they would work more closely with practising pharmacists.

8.7. Some respondents mentioned that our proposed changes would also mean that supervisors would benefit from better training and support mechanisms. They would therefore be able to develop further in their roles.

Negative impacts

On students

8.8. Many respondents commented on the financial impact of our proposals on students and were concerned that introducing an integrated degree could have a negative impact on students, and especially students from disadvantaged socio-economic backgrounds, mature students and international students. Their main concerns were that students would potentially have to pay for a fifth year of education and training and may not receive a salary during their learning in practice. Respondents also anticipated that several shorter learning in practice placements would translate to additional accommodation and travel costs for students. Respondents were concerned that school leavers would decide against studying for an MPharm degree because it would be too expensive for them.

8.9. A number of respondents were worried that, because of the increased number of placements and difficulty in organising them, students would not be able to decide where to undertake their placements and might feel less able to orientate their careers. Others were concerned
that not having a continuous year of training would impede students gaining independence in their work. Training providers explained that, in their experience, students become more autonomous at the end of their training.

**On schools of pharmacy**

8.10. Many respondents mentioned that integration would require schools to undertake significant transitions, which would be time and resource-intensive for them. They were concerned about the resource and financial impact placed on schools. Respondents mentioned increased costs to change and run admission procedures; to secure, organise and quality assure experiential learning and learning in practice placements; to appoint and train staff; and to administratively manage programmes. Respondents felt that without funding to undertake these new tasks it would be difficult to implement them.

8.11. Several respondents were concerned that modified admission criteria would also have a financial impact on schools. They explained that disallowing unconditional offers would remove a predictable income for schools and that stricter admission requirements would also lead to a loss of income. They were concerned that schools would have to close because MPharm degrees would no longer be viable.

8.12. Other respondents queried whether university places should match learning in practice placements, and whether the number of students would be capped.

**On training providers**

8.13. Training providers were concerned regular progression meetings would be difficult to organise due to time constraints in the workplace. They were concerned about the impact of this proposal on the workflow of pharmacies.

8.14. Respondents were unsure about how to organise learning in practice placements, which would start at different times, last for different lengths of time, and for students who were at different stages of their initial education and training.

8.15. A few respondents were concerned that the training of students would require more support from supervisors/teams, as students would undertake their learning in practice earlier in their initial education and training, and so have less knowledge.

8.16. Training providers suggested that working with different schools of pharmacy would mean having to take into consideration different approaches and requirements, which would also be resource intensive for them. Training providers also anticipated that needing to train all staff involved in the supervision of students to a higher standard (for example to ensure supervisors have the skills to teach and assess more advanced clinical skills) and the renewal of training material/courses would be expensive. They also considered that implementing and running our proposed changes would lead to increased administration costs. Respondents worried that, because of these costs, some current training providers might stop training students. Others believed new funding arrangements should be put in place to support training providers.

8.17. Some training providers were concerned that, because schools already have training agreements with specific training providers, they would only send their students to these sites.

8.18. Even if they acknowledged it was not best practice, a number of respondents explained that certain training providers currently relied on pre-registration trainees in their yearly workforce
planning. A few respondents explained that pre-registration trainees were counted in departmental workforce and supported weekend service provisions. They also mentioned that, with cuts to pharmacy budgets, a funded member of staff was indispensable in some places. For them, splitting the pre-registration year in several shorter placements at different stages of initial education and training would disrupt workplaces.

8.19. Training providers also explained that the current length of pre-registration placements enables employers to train students to their processes. Several providers, mainly from community and hospital sectors, explained that currently they hired pre-registration trainees after they registered as part of their recruitment strategies. They were concerned this recruitment route could be jeopardised by shorter learning in practice placements and that employers would have to spend more money on the recruitment and the training of junior pharmacists.

8.20. Some respondents were concerned that the introduction of shorter periods of learning in practice would mean that students would look for placements close to where they lived and that this would negatively impact training providers located in less populated and rural areas.

Next steps

8.21. This Consultation analysis report will be presented, alongside an Equality impact assessment (EIA), to the GPhC Council in September 2019.

8.22. We will be aiming to finalise new standards following a further round of stakeholder engagement and discussion. These discussions will need to explore issues relating to implementation and funding, and take account of what will be needed from the future pharmacist workforce to meet the needs of each country. We are planning to begin these further discussions with stakeholders in Autumn 2019 even if discussions might be carried out over a period of time.

8.23. We believe progress can be made more quickly in regard to the standards relating to selection and admission and equality, diversity and fairness as these are not dependent on decisions about integrating the five years of education and training. We will therefore review and engage on revised standards for these two domains in the Autumn and present them to the GPhC Council at a future meeting.
Appendix 1: The consultation

1. Policy background

1.1. One of our core regulatory activities is setting standards for the education and training of pharmacy professionals, including pharmacists, pharmacy technicians and pharmacist independent prescribers. Currently, we are in the middle of a significant review programme covering all our education standards, as stated in our Strategic Plan 2017-2020. To date, revised standards for the initial education and training of pharmacy technicians and standards for the education and training of pharmacist independent prescribers have been agreed.

1.2. The most common form of initial education and training (IET) for pharmacists in Great Britain is a four-year MPharm degree accredited by us, followed by 52 weeks of pre-registration training in one or more sectors of practice. During the pre-registration period trainees apply their knowledge and skills, and demonstrate their competence in an employment practice-setting. Following successful completion of this, they are required to pass a registration examination before being able to apply to join the pharmacist register. These requirements reflect the UK’s current membership of the European Union, and Directive 2005/36/EC, under which pharmacists must undergo at least five years’ full-time (or part-time equivalent) initial education and training. This must be made up of at least four years’ academic study and at least six months of patient-facing training in a community or hospital pharmacy towards the end of the five years. Schools of pharmacy (schools) are responsible for the design and delivery of the MPharm degree, which must meet the standards for the initial education and training of pharmacists (the standards), in order to be accredited by us.

1.3. The current standards were published in 2011. They set out our requirements for course providers (standards 1 to 9) and the skills, competencies and behaviours that students and trainees must have acquired before registering with the GPhC (standard 10 – learning outcomes). Revised learning outcomes were produced in 2013 (including input from key stakeholders) but this was not part of a full standards review and these learning outcomes were not implemented, as expected changes in government policy were not continued. Pre-registration requirements were published in a separate document, known as the pre-registration manual. The manual covers the knowledge, skills and competences that a pre-registration trainee needs to acquire by the end of the 52-week placement. The performance standards precede the 2011 standards and have not been reviewed after the introduction of the current standards.

1.4. The pace of change in pharmacy has increased in recent years with greater use of technology, and an increase in the range of services offered to people. There is also an increased expectation that pharmacists can help relieve some of the pressures in the wider NHS. The pharmacist’s role as a front-line healthcare professional has continued to develop. It takes them more and more often into GP practices, care homes and people’s homes, as well as into the more familiar settings of community pharmacy, hospitals, industry and academia.

1.5. Pharmacists need to be equipped to play a central role in providing clinical services to people in these diverse working environments. They also need to operate in multi-professional teams across health and care settings, contributing to the improvement of the health and wellbeing of people.
1.6. In order to revise the standards, we commissioned research on pharmacists’ preparedness for practice, met with all schools of pharmacy, convened several expert groups, asked accreditation panel members and inspectors for their views, and engaged with the three countries’ training commissioning bodies. We then drafted revised standards, before consulting on them.

1.7. Between January and April 2019, we consulted on our proposals for the initial education and training of pharmacists.

2. Summary of our proposals

2.1. In order to ensure that future pharmacists are appropriately prepared for their future roles, we proposed key changes in the following areas:

- **Learning outcomes:** focused on four themes – person-centred care; professionalism; professional knowledge and skills; and collaboration. The proposed learning outcomes retain the critical importance of science as the underpinning feature of initial education and training for pharmacists, but have a greater focus on applying that scientific knowledge in practice. The learning outcomes are more heavily focused on clinical skills, multi-professional learning, and the importance of communicating effectively with patients and members of the public. We see this increased focus on clinical and communication skills and multi-professional learning as essential to equipping pharmacists with the flexibility they will need in the future. We also believe it will develop the confidence of pharmacists to play a leading role in person-centred care – something which has been raised with us consistently while we have been developing these new standards.

- **Standards for providers:** we proposed several changes to our standards for course providers. In regard to equality, diversity and fairness, we suggest strengthening our standards by requiring providers to conduct an annual review of student performance and admissions by the protected characteristics as set out in the Equality Act 2010. We will also require evidence of the action taken to examine the reasons for any differences and to address the situations where students are disadvantaged.

- **Integrating the five years of initial education and training:** in order to deliver the learning outcomes with the increased focus on clinical skills, on communicating with patients and on working effectively with other health and care professionals, we believe there must be a much stronger link between the currently separate elements of academic study in the MPharm degree and the practical experience in the pre-registration year. As a result, we proposed setting the learning outcomes to be achieved over five years. That would require universities, employers, health education and training organisations and those responsible for funding to work collaboratively to achieve this. We did not propose specific models stating how this could be achieved. We believe there are likely to be different ways and models both within and across the countries of Great Britain. We will ensure that our accreditation methodology allows for diversity and innovation in delivery.

- **Selection and admission:** we proposed to strengthen the standards by requiring providers to assess the values of prospective students in addition to their academic qualifications. By that we mean their interest in person-centred care, ability to work with other people, professionalism, problem-solving abilities, and numeracy skills. To help achieve this we would require providers to build interactive activities into their admissions processes, for
example multiple mini-interviews and group work. As well as contributing to an assessment of professional skills and attributes, this will also allow providers to assess the overall communication skills of prospective students.

- **Experiential learning and inter-professional learning:** we proposed that student pharmacists must have exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competency to achieve the learning outcomes. Our proposed standards also state that student pharmacists must participate in inter-professional learning. Engagement with students from other health and care professions would begin at an early stage, progressing to more complex interactions. This would enable student pharmacists to meet the GPhC learning outcomes.

- **Learning in practice supervision:** as we are proposing to set learning outcomes for five years, it follows there would be no separate set of pre-registration performance standards. The learning in practice components of the course would count towards the registration requirement for 52 weeks of practical learning. We would expect a more rigorous and structured approach to learning in practice with more regular and documented progress meetings.

### 3. About the consultation

#### Overview

3.1. The consultation was open for 12 weeks, beginning on 9 January and ending on 3 April 2019. To make sure we heard from as many individuals and organisations as possible:

- we launched an online survey, which was available for individuals and organisations to complete throughout the consultation period. We also accepted postal and email responses
- we organised a series of stakeholder events and a webinar aimed at pharmacy professionals, pharmacy service users, organisations and other interested parties
- we met with a number of key stakeholders across the three countries we regulate
- we attended a series of stakeholder events, including Local Pharmaceutical Committee (LPC) meetings across England
- we promoted the consultation through a press release to the pharmacy trade media, via our social media and through our e-bulletin Regulate
- we created a toolkit of materials for organisations to disseminate information about the consultation to their members, including a press release and a presentation
- we sent several reminders to the consultation before the closing date.

#### Survey

3.2. We received a total of 650 written responses to our consultation. 542 of these respondents identified themselves as individuals and 108 responded on behalf of an organisation.

3.3. Of these, 621 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.
3.4. Alongside these, we received 29 responses from individuals and organisations writing more generally about their views.

**Stakeholder events**

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

- We held three stakeholder events in London, Cardiff and Edinburgh, reaching 86 pharmacy stakeholders.
- We spoke at 33 speaking engagements across England, Scotland and Wales, reaching 1,310 stakeholders including pharmacy professionals, educators, employers, students and pre-registration trainees.
- We hosted an online webinar, which 900 stakeholders have viewed.

**Patient focus groups**

3.6. We organised three patient focus groups, held in London, Cardiff and Glasgow, and attended by 58 members of the public.

3.7. These focus groups provided valuable insights regarding pharmacy users’ expectations.

**4. Our approach to analysis and reporting**

**Overview**

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

4.2. The different routes through which individuals and organisations could contribute to the consultation meant that some duplication was inevitable. For example, some organisations have met with us at one-to-one meetings and events, and have also submitted a written response. Some organisations were also able to mobilise individual members to respond to us directly.

4.3. The key element of this consultation was a self-selection survey, which was hosted on the Smart Survey online platform. As with any consultation, we expect that individuals and groups who view themselves as being particularly affected by the proposals, or who have strong views on the subject matter, are more likely to have responded.

4.4. 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.

4.5. 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.

4.6. For transparency, Appendix 1 provides a list of the organisations that have engaged in the consultation through the online survey, email responses and/or their participation in meetings.
and events. A small number of organisations asked for their participation to be kept confidential and their names have been withheld.

4.7. The consultation questions are provided in Appendix 2.

**Quantitative analysis**

4.8. 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.

4.9. 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.

4.10. A small number of multiple responses (10 in total) 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.

4.11. 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.

4.12. Figures in the report are shown without decimal places and have been rounded to the nearest whole number. This approach means that the percentages reported in the tables do not always add up to 100%. This rounding also results in differences of up to one percentage point when combining two or more response categories. In addition, whenever a figure of less than 1% has been reported in the tables, it has been represented as <1%.

4.13. All questions were mandatory, but routing was used where appropriate to enable respondents to skip questions that weren’t relevant.

4.14. Cells with no data are marked with a dash.

**Qualitative analysis**

4.15. 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, patients and members of the public engagement events.

4.16. 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.

4.17. 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.
4.18. 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. 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.

The consultation survey structure

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

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

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

**Category of respondents**

**Table 18:** Responding as an individual or on behalf of an organisation

<table>
<thead>
<tr>
<th>Are you responding: (Base: all respondents)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>As an individual</td>
<td>519</td>
<td>84%</td>
</tr>
<tr>
<td>On behalf of an organisation</td>
<td>102</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>621</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Profile of individual respondents**

**Table 19:** Countries

<table>
<thead>
<tr>
<th>Where do you live? (Base: all individuals)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>448</td>
<td>86%</td>
</tr>
<tr>
<td>Scotland</td>
<td>36</td>
<td>7%</td>
</tr>
<tr>
<td>Wales</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>519</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Table 20:** Respondent type

<table>
<thead>
<tr>
<th>Are you responding as: (Base: all individuals)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A pharmacist</td>
<td>409</td>
<td>79%</td>
</tr>
<tr>
<td>A pharmacy technician</td>
<td>32</td>
<td>6%</td>
</tr>
<tr>
<td>A pre-registration trainee pharmacist</td>
<td>26</td>
<td>5%</td>
</tr>
<tr>
<td>A pre-registration trainee pharmacy technician</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>A pharmacy student</td>
<td>23</td>
<td>4%</td>
</tr>
<tr>
<td>A member of the public</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>519</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
### Table 21: Prescribers

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>An independent prescriber</td>
<td>70</td>
<td>17%</td>
</tr>
<tr>
<td>A supplementary prescriber</td>
<td>3</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Both an independent and supplementary prescriber</td>
<td>25</td>
<td>6%</td>
</tr>
<tr>
<td>None of the above</td>
<td>311</td>
<td>76%</td>
</tr>
</tbody>
</table>

**Total N of responses**: 409 100%

### Table 22: Pharmacy owners

<table>
<thead>
<tr>
<th>Are you a pharmacy owner or employer? (Base: individual pharmacists &amp; Pharmacy technicians)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>38</td>
<td>9%</td>
</tr>
<tr>
<td>No</td>
<td>403</td>
<td>91%</td>
</tr>
</tbody>
</table>

**Total N of responses**: 441 100%

### Table 23: Main area of work

<table>
<thead>
<tr>
<th>Sector (Base: individuals excluding pharmacy students and members of the public)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community pharmacy</td>
<td>170</td>
<td>35%</td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>143</td>
<td>29%</td>
</tr>
<tr>
<td>Prison pharmacy</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Primary care organisation</td>
<td>25</td>
<td>5%</td>
</tr>
<tr>
<td>GP practice</td>
<td>30</td>
<td>6%</td>
</tr>
<tr>
<td>Care home</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Pharmaceutical industry</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>Research, education or training</td>
<td>73</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Total N of responses**: 488 100%
### Table 24: Size of community pharmacy

<table>
<thead>
<tr>
<th>Size of pharmacy chain (Base: individuals working in community pharmacy)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent pharmacy (1 pharmacy)</td>
<td>25</td>
<td>15%</td>
</tr>
<tr>
<td>Independent pharmacy chain (2-5 pharmacies)</td>
<td>29</td>
<td>17%</td>
</tr>
<tr>
<td>Small multiple pharmacy chain (6-25 pharmacies)</td>
<td>22</td>
<td>13%</td>
</tr>
<tr>
<td>Medium multiple pharmacy chain (26-100 pharmacies)</td>
<td>16</td>
<td>9%</td>
</tr>
<tr>
<td>Large multiple pharmacy chain (Over 100 pharmacies)</td>
<td>78</td>
<td>46%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>170</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 25: Design and/or delivery of pharmacist education and training

<table>
<thead>
<tr>
<th>Are you involved in the design and/or delivery of pharmacist education and training? (Base: all individuals excluding pharmacy students)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>217</td>
<td>44%</td>
</tr>
<tr>
<td>No</td>
<td>279</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>496</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 26: Main role in the design and/or delivery of pharmacist education and training

<table>
<thead>
<tr>
<th>What is your main role in the design and/or delivery of pharmacist education and training? (Base: those involved in pharmacy education and training)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of School</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Course or programme leader</td>
<td>22</td>
<td>10%</td>
</tr>
<tr>
<td>University tutor/lecturer</td>
<td>32</td>
<td>15%</td>
</tr>
<tr>
<td>Teacher practitioner</td>
<td>12</td>
<td>6%</td>
</tr>
<tr>
<td>Pre-registration tutor/supervisor</td>
<td>60</td>
<td>28%</td>
</tr>
<tr>
<td>Pre-registration employer</td>
<td>12</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>75</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>217</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
### Profile of organisational respondents

**Table 26: Pharmacy organisation**

<table>
<thead>
<tr>
<th>Is your organisation: (Base: all organisations)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>a pharmacy organisation</td>
<td>78</td>
<td>76%</td>
</tr>
<tr>
<td>a non-pharmacy organisation</td>
<td>24</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>102</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Table 27: Type of organisation**

<table>
<thead>
<tr>
<th>Please choose the option below which best describes your organisation (Base: all organisations)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation representing patients or the public</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Organisation representing pharmacy professionals or the pharmacy sector</td>
<td>22</td>
<td>22%</td>
</tr>
<tr>
<td>Independent pharmacy (1 pharmacy)</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Independent pharmacy chain (2-5 pharmacies)</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Small multiple pharmacy chain (6-25 pharmacies)</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Medium multiple pharmacy chain (26-100 pharmacies)</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Large multiple pharmacy chain (over 100 pharmacies)</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>NHS organisation or group</td>
<td>30</td>
<td>29%</td>
</tr>
<tr>
<td>Research, education or training organisation</td>
<td>27</td>
<td>26%</td>
</tr>
<tr>
<td>Government department or organisation</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Regulatory body</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>102</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Table 28: Involvement in the delivery or commissioning of pharmacist education and training**

<table>
<thead>
<tr>
<th>Is the organisation you represent involved in the delivery or commissioning of pharmacist education and training? (Base: all organisations)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>75</td>
<td>74%</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>102</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
### Table 29: Role in the delivery or commissioning of pharmacist education and training

<table>
<thead>
<tr>
<th>Role in the delivery or commissioning of pharmacist education and training</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of the MPharm</td>
<td>23</td>
<td>31%</td>
</tr>
<tr>
<td>Delivery of pharmacist pre-registration training</td>
<td>30</td>
<td>40%</td>
</tr>
<tr>
<td>Commissioning of pharmacist education and training</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>75</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### 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 3: Organisations

The following organisations engaged in the consultation through the online survey, stakeholder engagement, one-to-one meetings, speaking events and email responses:

- Abertawe Bro Morgannwg Health Board
- Academy of Pharmaceutical Sciences (APS)
- Association of Independent Multiple Pharmacies (AIM)
- Aston University
- Avicenna
- Betsi Cadwaladr University Health Board
- Birmingham and Solihull and Wolverhampton Local Pharmaceutical Committees
- Board of Community Health Councils in Wales
- Boots Pharmacists Association
- Boots UK
- Britannia Pharmacy
- British Oncology Pharmacy Association (BOPA)
- British Pharmaceutical Students’ Association (BPSA)
- Buckinghamshire Local Pharmaceutical Committee
- Burdon Pharmacies
- Buttercups Training Ltd
- Cambridge University Hospitals
- Camden and Islington Local Pharmaceutical Committee
- Cardiff University
- Central and North West London NHS Foundation Trust (CNWL)
- College of Mental Health Pharmacy (CMHP)
- Community Health Voice
- Community Pharmacy Humber
- Community Pharmacy NI (CPNI)
- Community Pharmacy Scotland (CPS)
- Community Pharmacy Wales
- Community Pharmacy Wales (Aberystwyth)
- Community Pharmacy Wales (Cardiff)
- Community Pharmacy Wales (Narberth)
- Community Pharmacy Wales (North Wales)
- Community Pharmacy Wales (Swansea)
- Company Chemists’ Association (CCA)
- Coventry Local Pharmaceutical Committee
- Chief Pharmaceutical Officers (CPhO)
- De Montfort University
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire Local Pharmaceutical Committee
- Directors of Pharmacy Scotland
- Dorset Local Pharmaceutical Committee
- East Midlands Pre-registration Training Group
- East Sussex Better Together VTS Pilot Programme Board
- Gloucestershire Hospitals NHS Foundation Trust
- Great North Clinical Pharmacy Network (NE England)
- Greater Manchester Local Pharmaceutical Committee
- Guild of Healthcare Pharmacists (GHP)
- Health Education and Improvement Wales (HEIW)
- Health Education England (HEE)
- Healthcare Improvement Scotland
- Healthwatch Barnsley
Highland Pharmacy Education and Research Centre
James McKeeever Ltd Muirend Pharmacy
Keele University
King's College Hospital
King's College London
Kingston University
Leeds Teaching Hospitals NHS Trust
LGBT Foundation
Liverpool John Moores University
MB Health
McKesson UK
MediCare Pharmacy Group
Medicure Pharmacy
Michael Franklin Chemists Ltd
Monkbar Pharmacy
National Pharmacy Association (NPA) - England
National Pharmacy Association (NPA) - Scotland and Wales
Newcastle University
NHS Barnsley Clinical Commissioning Group
NHS Education for Scotland (NES)
NHS England and NHS Improvement
NHS Grampian
NHS Grampian Area Pharmaceutical committee
NHS Greater Glasgow and Clyde Area Pharmaceutical Committee
NHS Lothian
Norfolk and Suffolk NHS Foundation Trust (NSFT)
Norfolk Local Pharmaceutical Committee
Northern Lincolnshire and Goole NHS Trust
Nottingham University
Nottingham University Hospitals NHS Trust
O'Brien's Pharmacy Group
PAGB
PCT Healthcare Ltd
Pharmaceutical Services Negotiating Committee (PSNC)
Pharmaceutical Society of Northern Ireland (PSNI)
Pharmacists' Defence Association (PDA)
Pharmacy Forum of Northern Ireland F
Pharmacy London (London-wide Local Pharmaceutical Committee Group)
Pharmacy Schools Council (PhSC)
Pharmacy Schools Council (PhSC)
Postgraduate Pharmacy Task Group
Pre-registration Advisory Group Yorkshire and Humber
Preston's College
Primary Care Pharmacy Association (PCPA)
Queen's University
Research Strategy Implementation Group (RSIG)
Robert Gordon University
Rowlands Pharmacy
Royal College of General Practitioners (RCGP)
Royal College of Physicians (RCP)
Royal Pharmaceutical Society (RPS)
Royal Pharmaceutical Society (RPS) Scotland
Royal Pharmaceutical Society (RPS) Wales
Sandwell Local Pharmaceutical Committee
Scottish Government
Scottish Hospital Pharmacist Education and Training Group
Sefton Local Pharmaceutical Committee
1. Aims and purpose of the project or policy

This paper

1.1 This Equality Impact Analysis (EIA) focuses on the equality and diversity implications of proposed changes to the standards for the initial education and training of pharmacists in order to give effect to the Public Sector Equality Duty under section 149 of the Equality Act 2010. This requires the General Pharmaceutical Council (GPhC) to have due regard to each of the statutory objectives, including the need to:

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

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

1.3 The EIA aims to help ensure that future standards do not unfairly affect people or groups sharing particular protected characteristics\(^2\). We aimed to identify any trends or issues that apply to

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

\(^2\) The Equality Act 2010 prohibits direct or indirect discrimination, or harassment on the basis of a protected characteristic (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation). There is a fundamental distinction between direct discrimination, on the one hand, and indirect discrimination on the other (Sections 13 and 19). Direct discrimination is where an individual receives less favourable treatment because of a protected characteristic. Indirect discrimination concerns a provision, criterion or practice that puts someone with a protected characteristic at a particular disadvantage, compared with people who do not
people or groups sharing particular protected characteristics and considered potential negative and positive impacts on them. The EIA focuses on how impacts on people or groups sharing particular protected characteristics have been considered in the standards development process and especially through our stakeholder engagement.

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

1.5 This EIA includes an overview of the work we have completed to inform our understanding of the equality and diversity dimensions of our proposals; and, to consider the potential impact on people or groups sharing particular protected characteristics. This has been informed by our quantitative and qualitative analysis of responses to the consultation; the available data and / or evidence relating to, and our engagement with, a wide variety of stakeholders.

1.6 We have updated the analysis throughout the different stages of the policy development process, including pre-consultation and during the consultation and engagement period.

1.7 The analysis is intended to assist Council in considering how we took into consideration equality and diversity in the development of our proposals so far.

1.8 We have sought to identify and mitigate any adverse impact on includes future pharmacists, people involved in their education and patients or members of the public interacting with them and using their services. We have also considered how the proposed changes can help make a positive impact on these groups.

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

Revising the initial education and training of pharmacists

1.10 As part of our regulatory work, we are responsible for setting standards and quality assuring the initial education and training of pharmacists to make sure pharmacists develop the knowledge, skills, attitudes and behaviours they need to provide the safe and effective care patients and the public expect from day one.

1.11 The pace of change in pharmacy has increased in recent years changing the roles of and expectations placed on pharmacists. We aim to review all our standards regularly and revise the standards for the initial education and training of pharmacists is a key priority for us to ensure that the future standards reflect the changing roles of pharmacists and anticipate future developments.

1.12 In order to ensure that future pharmacists are appropriately prepared for their future roles, we are proposing key changes in the following areas:

- **Learning outcomes**: focused on four themes – person-centred care; professionalism; professional knowledge and skills; and collaboration. The proposed learning outcomes retain shared the protected characteristic (Section 19). However, a provision, criterion or practice that causes a particular disadvantage is lawful if it is a proportionate means of achieving a legitimate aim.
the critical importance of science as the underpinning feature of initial education and training for pharmacists, but have a greater focus on applying that scientific knowledge in practice. The learning outcomes are more heavily focused on clinical skills, multi-professional learning, and the importance of communicating effectively with patients and members of the public. We see this increased focus on clinical and communication skills and multi-professional learning as essential to equipping pharmacists with the flexibility they will need in the future. We also believe it will develop the confidence of pharmacists to play a leading role in person-centred care – something which has been raised with us consistently while we have been developing these new standards.

• **Standards for providers**: we proposed several changes to our standards for course providers. In regard to equality, diversity and fairness, we suggest strengthening our standards by requiring providers to adopt a more proactive approach, conduct annual reviews of student performance and admissions by the protected characteristics as set out in the Equality Act 2010 and use that information in inform the design and delivery of programmes. We will also require evidence of the action taken to examine the reasons for any differences and to address the situations where students are disadvantaged.

• **Integrating the five years of initial education and training**: in order to deliver the learning outcomes with the increased focus on clinical skills, on communicating with patients and on working effectively with other health and care professionals, we believe there must be a much stronger link between the currently separate elements of academic study in the MPharm degree and the practical experience in the pre-registration year. As a result, we proposed setting the learning outcomes to be achieved over five years. That would require universities, employers, health education and training organisations and those responsible for funding to work collaboratively to achieve this. We did not propose specific models stating how this could be achieved. We believe there are likely to be different ways and models both within and across the countries of Great Britain. We will ensure that our accreditation methodology allows for diversity and innovation in delivery.

• **Selection and admission**: we proposed to strengthen the standards by requiring providers to assess the values of prospective students in addition to their academic qualifications. By that we mean their interest in person-centred care, ability to work with other people, professionalism, problem-solving abilities, and numeracy skills. To help achieve this we would require providers to build interactive activities into their admissions processes, for example multiple mini-interviews and group work. As well as contributing to an assessment of professional skills and attributes, this will also allow providers to assess the overall communication skills of prospective students.

• **Experiential learning and inter-professional learning**: we proposed that student pharmacists must have exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competency to achieve the learning outcomes. Our proposed standards also state that student pharmacists must participate in inter-professional learning. Engagement with students from other health and care professions would begin at an early stage, progressing to more complex interactions. This would enable student pharmacists to meet the GPhC learning outcomes.

• **Learning in practice supervision**: as we are proposing to set learning outcomes for five years, it follows there would be no separate set of pre-registration performance standards. The learning in practice components of the course would count towards the registration
requirement for 52 weeks of practical learning. We would expect a more rigorous and structured approach to learning in practice with more regular and documented progress meetings.

Policy context

1.13 The current standards for the initial education and training of pharmacists (the standards) were published in 2011. Pre-registration requirements were published in a separate document known as the pre-registration manual. The manual covers the knowledge, skills and competences that a pre-registration trainee needs to acquire at the end of the 52-week placement. The performance standards precede the 2011 standards and have not been reviewed after the introduction of the current standards.

1.14 An interim review was carried out in 2013 to examine the learning outcomes (knowledge, skills, understanding and professional behaviours a student pharmacist must demonstrate at the end of their initial educational and training before registration with the GPhC). This review was initiated in part because government initiatives to change the structure and funding of pharmacists’ education and training were progressing, including an in-principle decision to move towards a 5-year integrated degree (combining the MPharm and pre-registration year). The GPhC review process included engagement with a range of key stakeholders including the Pharmacy Schools Council. However, no decisions were made by governments across Great Britain and we did not take forward a formal consultation on the newly developed learning outcomes at that stage. During our pre-consultation stakeholder engagement we conducted in advance of this review of the IETP standards, we heard from schools of pharmacy that the learning outcomes drafted in 2013 were a step forward in terms of clinical practice and we will build on them in our review.

1.15 Since 2015, the GPhC Council has increased its focus on education and training in general, looking both at pharmacist education and training as well as the wider pharmacy workforce. The review of the standards for the initial education and training of pharmacists is part of a full education review programme covering all our education standards, as stated in our Strategic Plan 2017-2020. To date, we have agreed revised standards for the initial education and training of pharmacy technicians and standards for the education and training of pharmacist independent prescribers.

1.16 We have considered a wide range of information in developing our proposed changes for the initial educational and training of pharmacist. We commissioned independent research to give us more intelligence on pharmacists’ preparedness for practice. We worked with all schools of pharmacy and with many stakeholders involved in the education and training of pharmacists. We also brought together several expert groups to test specific aspects of the initial education and training of pharmacists, namely: prescribing, pre-registration training, and learning outcomes.

1.17 Initial pharmacy education and training must be based on principles of equality, diversity and fairness and we are proposing to strengthen our current requirements in this regard. Following pre-consultation engagement, we drafted and consulted on our proposed standards between January and April 2019. There is a much stronger emphasis on equality, diversity and fairness in the proposed standards we consulted on:

- Course design and delivery will have to ensure that student pharmacists understand and meet their legal responsibilities under equality and human rights legislation; respect diversity and cultural differences; and take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs.
- We are also proposing that education and training systems and policies must proactively promote the principles and legal requirements of equality, diversity and fairness. Providers will
have to carry out every year a review of student performance and admissions using the protected characteristics defined by the Equality Act 2010 and use that information in inform the design and delivery of programmes. We will require evidence from providers showing the action they have taken to examine the reasons for any differences in achievement analysed by protected characteristic and what they have done to address situations where students are disadvantaged.

- Providers will also have to ensure that all staff involved in the initial education and training of pharmacists are trained to apply principles and legal requirements of equality, diversity and inclusion in their role.

1.18 We analysed the consultation responses from survey respondents and from all stakeholders, patients and members of the public who participated in our consultation events in the consultation analysis report. The consultation analysis report (and this EIA) will be presented to the GPhC Council in September 2019.

1.19 We will ask the GPhC Council to consider revised standards for selection and admission and equality diversity and fairness in late 2019/early 2020. A further phase of stakeholder engagement needs to take place before standards for the five years of initial education and training can be introduced.

2. Review of available information

Legal framework

1.20 Article 4 of Pharmacy Order 2010 captures the principal functions and responsibilities of the Council. One of them is:

(e) to set standards and requirements in respect of the education, training, acquisition of experience and continuing professional development that it is necessary for pharmacists and pharmacy technicians to achieve in order to be entered in the Register or to receive an annotation in the Register and to maintain competence;

1.21 Part 5 of Pharmacy Order 2010 focuses on education, training and acquisition of experience. Article 45(1)(b) state that Council must set:

“(i) the standards of education, training and experience that providers of education and training must meet in order to enable a person undertaking such education or training, or acquiring such experience, to achieve the standards referred to in sub-paragraph (a) having regard, in particular, to the outcomes to be achieved, and
(ii) any requirements to be satisfied for admission to, and continued participation in, education and training for prospective pharmacists or prospective pharmacy technicians, which may include requirements as to fitness to practise unimpaired by health”.

1.22 Article 45(6)(b) also stipulates that Council must publish a statement of:

“(a) the criteria by reference to which the standards of education, training and experience referred to in paragraph (1)(b)(i) are set, and
(b) the criteria that will be taken into account in deciding whether to grant approval under paragraph (4), as they exist from time to time”.
1.23 In engaging with stakeholders and developing the standards, we also gave due regard to our statutory objectives under Section 149 of the Equality Act 2010 and we believe that the proposals align with our overarching legal objective which is the protection of the public\(^3\).

**Developing our evidence base**

1.24 We have carried out a systematic and evidence-based approach to our policy development, including an assessment of the equality and diversity dimensions of our proposals. We carried out desk-based research, commissioned pieces of research and analysed their findings, and considered intelligence gathered during patient, members of the public and stakeholder engagement.

**GPhC register data**

1.25 The information on our register enables us to understand the demographic make-up of the current pharmacist profession. The below data portrays a snapshot of those professionals on the GPhC register on 30 May 2019.

1.26 The information provided in this section has been split into two columns. The left-hand columns provide the equality and diversity data of all the pharmacists on the GPhC register on 30 May 2019 (‘All pharmacists’). The right-hand columns provide the protected characteristics of pre-registration trainees undertaking their placement during the 2018/19 academic year (‘Pre-registration trainees’). The right-hand columns enable us to understand the demographic make-up of individuals who are in the process of completing their initial education and training.

1.27 There were limits to the data we collected on gender reassignment, marriage/civil partnership, pregnancy/maternity, and sexual orientation. As a result, we modified our Equalities monitoring form to collect further protected characteristics data from pharmacists registering with us to address this gap. However, the new form was only introduced in 2016 and we are not able to provide data on all protected characteristics in this section.

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\(^3\) The Pharmacy Order 2010, Article 6(1)
Age

1.28 The majority of the pharmacists on our register in May 2019 were aged between 25 and 44 years old (66%).

1.29 Just above half of the pre-registration trainees in the academic year 2018/19 were under 25 years old (55%). Over one-third of them were aged between 25 and 34 years old (39%).

<table>
<thead>
<tr>
<th>Age</th>
<th>All pharmacists</th>
<th>Pre-registration trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Under 25</td>
<td>920</td>
<td>2%</td>
</tr>
<tr>
<td>25-34</td>
<td>21,415</td>
<td>38%</td>
</tr>
<tr>
<td>35-44</td>
<td>15,481</td>
<td>28%</td>
</tr>
<tr>
<td>45-54</td>
<td>10,048</td>
<td>18%</td>
</tr>
<tr>
<td>55-64</td>
<td>6,565</td>
<td>12%</td>
</tr>
<tr>
<td>65 and over</td>
<td>1,640</td>
<td>3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>56,069</td>
<td>100%</td>
</tr>
</tbody>
</table>

Disability

1.30 Under half of the pharmacists on our register in May 2019 stated they did not have a disability (43%). However, 56% of pharmacists did not respond to this question.

1.31 The vast majority of 2018/19 pre-registration trainees stated not to have a disability (97%). This percentage is much more reliable as only 2% of them did not respond to this question.

<table>
<thead>
<tr>
<th>Disability</th>
<th>All pharmacists</th>
<th>Pre-registration trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>No</td>
<td>24,247</td>
<td>43%</td>
</tr>
<tr>
<td>Yes</td>
<td>228</td>
<td>0%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>31,597</td>
<td>56%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>56,069</td>
<td>100%</td>
</tr>
</tbody>
</table>
1.32 Under half of the pharmacists on our register in May 2019 described themselves as ‘White’ (43%). The second highest group of pharmacists described themselves as ‘Asian’ (37%). Other ethnicities listed were significantly smaller with no figure above 10%.

1.33 Just above half of 2018/19 pre-registration trainees described themselves as ‘Asian’ (53%), whereas a quarter of them defined themselves as ‘White’ (25%) and 13 % as ‘Black’.

<table>
<thead>
<tr>
<th>Race</th>
<th>All pharmacists</th>
<th>Pre-registration trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Asian</td>
<td>20,965</td>
<td>37%</td>
</tr>
<tr>
<td>Black</td>
<td>3,603</td>
<td>6%</td>
</tr>
<tr>
<td>Mixed</td>
<td>421</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1,628</td>
<td>3%</td>
</tr>
<tr>
<td>White</td>
<td>24,228</td>
<td>43%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>5,224</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>56,069</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Religion or belief

1.34 More than half of the pharmacists on our register in May 2019 did not provide religion-related information (59%). Those who did stated they were Muslim (12%), Christian (12%), or did not have a religion (8%).

1.35 The vast majority of 2018/19 pre-registration trainees provided religion-related information (98%). 36% of them declared to be Muslim, 26% to be Christian and 20% not to have a religion.

<table>
<thead>
<tr>
<th>Religion</th>
<th>All pharmacists</th>
<th>Pre-registration trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Buddhist</td>
<td>583</td>
<td>1%</td>
</tr>
<tr>
<td>Christian</td>
<td>7,094</td>
<td>13%</td>
</tr>
<tr>
<td>Hindu</td>
<td>2,729</td>
<td>5%</td>
</tr>
<tr>
<td>Jewish</td>
<td>64</td>
<td>0%</td>
</tr>
<tr>
<td>Muslim</td>
<td>6,597</td>
<td>12%</td>
</tr>
<tr>
<td>None</td>
<td>4,392</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>312</td>
<td>1%</td>
</tr>
<tr>
<td>Sikh</td>
<td>1,168</td>
<td>2%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>33,130</td>
<td>59%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>56,069</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Sex

1.36 The majority of both pharmacists on our register in May 2019 and 2018/19 pre-registration trainees were women (62% and 61%).

<table>
<thead>
<tr>
<th>Gender</th>
<th>All pharmacists</th>
<th>Pre-registration trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Female</td>
<td>34,633</td>
<td>62%</td>
</tr>
<tr>
<td>Male</td>
<td>21,436</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>56,069</td>
<td>100%</td>
</tr>
</tbody>
</table>

GPhC commissioned surveys and reports

1.37 Over the past years we have commissioned and undertook research on the education and training of members of the pharmacy team including pieces of research focusing on the initial education and training of pharmacists. To inform this EIA, we used data from the following reports:

- The GPhC survey of 2012-2013 pre-registration
- Analysis of trainee dissatisfaction 2012-2013 pre-registration trainees
- The GPhC registrant survey 2013
- Tomorrow’s pharmacy team 2015
- Qualitative research into registration assessment performance among Black-African candidates
- Initial education and training and preparation for practice research 2017

1.38 The above-mentioned pieces of research were considered during the drafting process for the standards and we sought to ensure a broad range of groups were represented throughout our consultation and engagement process.

1.39 We considered the impacts raised by these pieces of research in Section 6 of this EIA (Full impact analysis).

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4 The GPhC Registrant survey 2013
5 Tomorrow’s pharmacy team 2015
6 Qualitative research into Registration Assessment performance among Black-African candidates – Issues faced by Black-African candidates and preliminary responses 2016
3. Additional information relevant to equality and diversity issues

This table shows if this project or policy has any relevance to the equality and diversity issues below. If it is relevant to any of these issues, a full equality impact analysis will need to be carried out.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Relevant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
</tr>
<tr>
<td>Disability</td>
<td>✓</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td></td>
</tr>
<tr>
<td>Marriage or Civil Partnership</td>
<td>✓</td>
</tr>
<tr>
<td>Pregnancy/Maternity</td>
<td>✓</td>
</tr>
<tr>
<td>Race</td>
<td>✓</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>✓</td>
</tr>
<tr>
<td>Sex</td>
<td>✓</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>✓</td>
</tr>
<tr>
<td>Welsh Language Scheme</td>
<td>✓</td>
</tr>
<tr>
<td>Other identified groups</td>
<td>✓</td>
</tr>
</tbody>
</table>

4. Decision on impact

Based on the answers above, does this project or policy require a full impact analysis? This decision takes into account whether this policy or project would result in a substantial change or overall impact for pharmacy.

Yes ☒ No ☐

Yes, full EIA required.

4.1 We marked ‘Yes’ against categories in the screening table where we believe there may be impacts on those with protected characteristics.

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

4.3 Please see our analysis of the impact questions included as part of the consultation in section 5 below.

5. Consultation and involvement

Pre-consultation engagement

5.1 We undertook a comprehensive phase of stakeholder engagement before we started drafting proposed revised standards. As part of the pre-consultation engagement, we undertook the following activities:

- We met with all schools of pharmacy (SoPs) and various other education stakeholders from September to November 2018 to develop a better understanding of the needs for pharmacists’ education and training.
We commissioned research to provide us with intelligence on pharmacists’ preparedness for practice and gathered the views of recently registered pharmacists, employers/supervisors of recently registered pharmacists and policy makers.

We organised a scoping meeting with the British training commissioning bodies (Health Education England (HEE), NHS Education Scotland (NES), Workforce Education and Development Service (WEDs)/ Health education and improvement Wales (HEIW) and the Wales Centre for Pharmacy Professional Education (WCPPE). The nature of the meeting was to examine our role and their role in pre-registration and explore the possibility of delegating functions.

We convened three expert groups to test specific elements of the initial education and training of pharmacists (the learning outcomes, prescribing skills and competences to be incorporated into the initial education and training of pharmacists and pre-registration).

We met with accreditation panel members and inspectors to gather their views on the current standards and on revised learning outcomes.

We also organised meetings with Nottingham University and the University of East Anglia to discuss their experience of five-year integrated MPharm degrees.

5.2 This level of stakeholder engagement prior to drafting revised standards was also intended to provide a degree of external assurance to the GPhC and Council on the suitability of our revised standards.

5.3 No specific issues regarding protected characteristics were raised during the pre-consultation period apart from schools of pharmacy and members of the task and finish group on pre-registration explaining that students and trainees can struggle with the concept of inclusivity. It was therefore agreed during the drafting of the standards that there was a need for further emphasis on equality and diversity within the standards and we took into consideration this feedback in our revised proposed requirements (please refer to 1.18).

Formal consultation

Overview

5.4 The consultation was open for 12 weeks, beginning on 9 January and ending on 3 April 2019. To make sure we heard from as many individuals and organisations as possible:

- we launched an online survey, which was available for individuals and organisations to complete throughout the consultation period. We also accepted postal and email responses
- we organised a series of stakeholder events and a webinar aimed at pharmacy professionals, pharmacy service users, organisations and other interested parties
- we met with a number of key stakeholders across the three countries we regulate
- we attended a series of stakeholder events, including Local Pharmaceutical Committee (LPC) meetings across England
- we promoted the consultation through a press release to the pharmacy trade media, via our social media and through our e-bulletin Regulate
- we created a toolkit of materials for organisations to disseminate information about the consultation to their members, including a press release and a presentation
- we sent several reminders to the consultation before the closing date

Survey

5.5 We received a total of 650 written responses to our consultation. 542 of these respondents identified themselves as individuals and 108 responded on behalf of an organisation.

5.6 Of these, 621 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.

5.7 Alongside these, we received 29 responses from individuals and organisations writing more generally about their views.

5.8 Data was collected on respondents’ protected characteristics, as defined within the Equality Act 2010. The GPhC’s equalities monitoring form was used to collect this information, using categories that are aligned with the census, or other good practice (for example on the monitoring of sexual orientation). 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. The full results of the equality monitoring for consultation respondents and focus group participants can be found in Appendix 1 of this document.

Stakeholder events

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

- We held three stakeholder events in London, Cardiff and Edinburgh, reaching 86 pharmacy stakeholders.
- We spoke at 33 speaking engagements across England, Scotland and Wales, reaching 1,310 stakeholders including pharmacy professionals, educators, employers, students and pre-registration trainees.
- We hosted an online webinar, which 900 stakeholders have viewed.

Patient focus groups

5.10 We organised three patient focus groups, held in London, Cardiff and Glasgow, and attended by 58 members of the public.

5.11 These focus groups provided valuable insights regarding pharmacy users’ expectations. They were particularly useful in reaching those groups who were less likely to respond to the consultation via the online form.

5.12 As part of the consultation (survey, stakeholder events and patient focus groups), we asked respondents and participants to share their views on the impact of our proposals on individuals or groups who share any of the protected characteristics and on other groups. Their responses have been analysed in Section 6 of the EIA (Full impact assessment).
6. Full impact analysis

Age

Observed trends

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

6.2 Our qualitative analysis undertaken prior to consultation identified some noticeable trends:

- Just above half of the pre-registration trainees in the academic year 2018/19 were under 25 years old (55%). Over one-third of them were aged between 25 and 34 years old (39%). Only a small number of mature students undertake an MPharm degree.
- The 2013 registrants survey observes that younger pharmacists tend to work in large pharmacy chains (52%) and hospital settings (27%), whereas older pharmacists tend to work in smaller local pharmacies (44%) \(^7\).

Impact of setting standards for the five years of education and training

6.3 We heard during the pre-consultation stakeholder engagement phase that our proposal to set standards for the five years of the initial education and training of pharmacists would have a positive impact on younger pharmacists. Stakeholders felt that integrating academic study and practice learning would strengthen students’ confidence, leadership skills and understanding of what it means to be a healthcare professional. Pre-consultation research and engagement showed those aspects were sometimes lacking in the performance of newly registered pharmacists. Several schools of pharmacy also mentioned that the concept of professionalism was difficult to understand for younger pharmacy students. Stakeholders agreed that integrating theoretical and practical learning would enable pharmacist students to consider themselves as professionals and raise their confidence from an earlier stage.

6.4 Qualitative research undertaken on the registration assessment performance among Black-African candidates showed that age, combined with other factors, had an impact on success during studies\(^8\). It can be more difficult for mature students to be as successful in their studies as younger students due to additional family commitments and financial responsibilities. These factors can adversely impact on learning, as well as time to complete the additional study required. Mature students are also less likely to form the supportive peer networks that are described as important for success. They are also more likely to choose education and training providers which are closer to where they live, which can have an impact on the quality of their training. The pre-registration survey (2012) found that trainees over 30 years old (19%) were more likely to be dissatisfied with their training or to describe their experience of pre-registration as very poor compared to those under 30 years old (9%).

6.5 We heard, during the consultation, that some respondents were concerned that mature students might no longer consider studying for an MPharm degree if they had to self-finance a fifth year of education and training because of having other monetary obligations such as paying a mortgage or

\(^7\) The GPhC Registrant survey 2013
\(^8\) Qualitative research into registration assessment performance among Black-African candidates: Report to the GPhC 2016
supporting their family. Some respondents also mentioned that mature students were more likely to have caring responsibilities and so might be less able to alternate between periods of learning at the university with periods of learning in practice. In that regard, respondents thought that mature students would be more affected by routine changes and less able to relocate for their learning in practice.

6.6 However, we also heard during the pre-consultation stakeholder engagement that the integration of theoretical and practical learning could benefit mature students. Stakeholders explained that, as schools’ involvement in learning in practice would be more important, the overall quality and consistency of learning in practice would be raised. Stakeholders felt that the increased scrutiny on the transition between education and training, and the fact that courses would be more structured and adapted to students learning needs, would also benefit students. They felt that a greater control over learning in practice placements might be more suited to the learning needs of students, including mature students who are juggling additional commitments.

Impact of our proposed changes for selection and admission

6.7 Before the consultation, most schools agreed that admissions should be more than just a test of academic ability and should include an assessment of a person’s ability to practise as a healthcare professional. However, many schools of pharmacy explained that it was difficult to assess the professional values of candidates applying to study on an MPharm degree as many of them may not be fully mature emotionally when applying to university. During the consultation, a large number of respondents also thought that our proposals could negatively affect young people. In their view, young applicants might find it difficult to display professional attitudes and would struggle to demonstrate that they have the potential to be a professional pharmacist at the age of 17, 18 or 19.

6.8 During the consultation, many of the respondents who provided feedback were concerned about the impact of our selection and admission proposals on mature students. They were worried that prescriptive academic requirements may adversely impact mature students who did not achieve the required grades at A-level or had atypical qualifications. For them, raising MPharm entry academic requirements could potentially reduce the number of mature students who choose to study for an MPharm. Other respondents, however, pointed out that assessing applicants’ skills and attributes would take into consideration the experience, knowledge and skills mature students have acquired and could benefit them.

Mitigations

6.9 We embedded equality, diversity and fairness in the proposed standards. Domain 2, in our proposed requirements for providers, requires course developers and providers to proactively give due consideration to equality, diversity and fairness in course design and delivery. Providers must have systems and policies in place to enable staff to understand the diversity of the student body and its implications for course delivery, student support and development. Domain 2 also requires providers to conduct annual reviews of student performance by protected characteristics and to document actions taken to address differences when they are found.

6.10 We are therefore planning a second phase of stakeholder engagement, which will start in the Autumn 2019, to explore ways in which the integration of academic study and practice learning can be funded.

6.11 In relation to selection and admission, we want to make sure than any requirements set are justified and proportionate and do not unnecessarily impede prospective students from applying. The proposed set of standards we consulted on at the beginning of the year state that admission
processes must include a face-to-face component, in order to assess professional suitability. This can include Skype/Facetime sessions for applicants unable to attend admissions/selections events in person. Our proposed standards also mention that providers must annually analyse the profile, by protected characteristics, of students admitted onto their MPharm degree and take documented actions when admissions processes disadvantage specific groups of students (Domain 1).

6.12 We will take into consideration the feedback provided during the consultation when we revise the standards, before presenting new standards for selection and admission and for equality, diversity and fairness to Council in late 2019/early 2020.

6.13 After the revised standards are approved, we will develop an evidence framework. This guidance will support and assist course developers and designers as they implement the standards. The evidence framework will also provide further information about how our requirements on equality and diversity must be embedded in course design and delivery.

6.14 In monitoring the impact of the standards, our accreditation process will then require schools of pharmacy to provide evidence to demonstrate how they apply and meet our standards.

Disability

Impact of revising our learning outcomes

6.15 During the consultation, a few respondents were concerned that some individuals with disabilities might not be able to meet the learning outcomes because of their disabilities (e.g. severe visual impairments) or being less able to communicate and to show empathy. For instance, respondents felt that people with some disabilities may be physically or mentally unable to help or respond in stressful situations and deliver first aid.

Impact of setting standards for the five years of education and training

6.16 During the consultation, several respondents were also concerned about the support provided to disabled students while in learning in practice. They explained that the support provided by universities was usually better than training providers. They worried that, in an integrated degree, this lack of support from training providers might negatively impact students who also need reasonable adjustments during their training. For them, there should be early consideration of how adjustments should be organised for students during their periods of learning in practice. In their view, a greater degree of planning around placements should be undertaken to enable training providers to organise the appropriate reasonable adjustments for students with disabilities. A few respondents also indicated that disabled people may need placements closer to home, with a carpark or with a wheelchair access.

6.17 Several respondents indicated that having to undertake several shorter learning in practice placements in different organisations might negatively impact students who have physical disabilities as they could find constant relocations challenging. Others mentioned that disabled people could be put off by having to regularly communicate their needs for reasonable adjustments to training providers. Other respondents thought that disabled students might be negatively impacted if they were no longer able to undertake their learning in practice part-time. They explained that there are significant differences in the physical and mental demands of full-time education and full-time work.

6.18 A few respondents wondered whether integrated learning would support or hinder neurodiverse students (for example students with dyslexia, or ADHD) and students with mental health problems. A small number of respondents proposed that, if done well, integrating learning may
support students who prefer ‘action-based learning’. However, others mentioned that integrated learning may equally pose challenges to this student group, especially when splitting the existing pre-registration year to a range of clinical settings (community pharmacy, hospital and GP surgeries). For them, this would be unsettling for some students and not give them enough time to gain a deeper appreciation of a clinical setting which interests them and/or supports their learning style.

**Impact of our proposed changes for selection and admission**

6.19 A number of respondents felt that individuals with particular difficulties in communicating (for example people with autism spectrum disorders) might be negatively impacted by our proposal to assess the skills and attributes of applicants during admission procedures. They felt that if a disability made an individual less able to communicate or show empathy with others it would make it difficult for them to achieve a successful application. Other respondents believed that disabled people generally had lower grades and that setting more prescriptive academic requirements would have an impact on them joining MPharm degrees.

**Mitigations**

6.20 We aim to ensure that the standards we set do not negatively impact people with disabilities. All learning environments are required to comply with the Equality Act 2010 and providers must ensure that there are no barriers to those who require a reasonable adjustment during their education and training.

6.21 Education and training providers have to make sure staff are aware of the fact that certain students have more difficulties in adapting to specific teaching or training approach and encourage staff to undertake a more proactive approach to ensure all students benefit from their teaching and training.

6.22 Education and training providers will have to ensure reasonable adjustments are organised to enable students to meet the learning outcomes. The learning outcomes are required to ensure pharmacists are appropriately prepared for their future roles and provide safe and effective pharmacy services. To ensure patient safety, some individuals, even after reasonable adjustments, may not be able to meet the outcomes for reasons related to a disability or health condition.

6.23 In our proposed standards we also encourage education and training providers to look at ways to improve the feedback they provide (Domain 6) and to get the views of a range of stakeholders and take account of them when designing and delivering initial education and training.

6.24 Setting standards for the five years of initial education and training could potentially strengthen the support that students with disabilities receive during their learning in practice as schools of pharmacy will have a greater control over learning in practice. Schools of pharmacy will have greater responsibility to ensure that students requiring reasonable adjustments are appropriately supported during their learning in practice placement.

6.25 In our proposed requirements for the initial educational and training of pharmacists, Domain 1 (selection and admission) requires schools of pharmacy to annually analyse the admission profile of students by protected characteristics, as defined in the Equality Act 2010, and to document actions undertaken if the analysis of the admissions process identifies disadvantages to particular groups of students. Domain 1 also requires that selectors’ training includes equality and diversity awareness.
6.26 In our proposed Domain 7 (Support and development for student pharmacists and people delivering initial education and training) we require from providers to have clear procedures in place for students to raise concerns. Providers will need to demonstrate how they support students in this during accreditation events.

6.27 We will take into consideration the feedback provided by stakeholder during the consultation when we revise the standards to ensure their concerns are addressed.

6.28 In addition, the evidence framework will provide clarity for providers about how they can meet our standards to ensure providers are aware of their responsibilities in the design and delivery of the initial education and training of pharmacists.

Gender reassignment

6.29 We do not envisage, nor have evidence to suggest, any disproportionate impact of the proposals in relation to gender reassignment.

Marriage or Civil Partnership

6.30 Please refer to section on pregnancy and maternity as the issues brought up during the consultation are identical for both protected characteristics.

Pregnancy or maternity

6.31 We heard during the consultation that respondents had diverging views on the impact of our proposals on students who are married, pregnant, on parental leave, or who have caring responsibilities. Some respondents felt that students who are pregnant, on parental leave or with children may be disadvantaged as it might be more difficult for them to temporarily pause their education or training in an integrated programme, or because they will be less flexible to relocate for their placements. These respondents thought that the management of a 5-year course should take into consideration that some students would need to take parental leave or to have part-time provisions possible for students with dependents. Other respondents were of the opinion that having the opportunity to complete learning in practice over a period of five years would benefit anyone requiring parental leave, as they would not be under the same pressure to postpone the pre-registration year in one go. These respondents proposed that students should be able to 'bank' their competencies until they return from parental leave.

Mitigation

6.32 We aim to ensure that the standards we set do not negatively impact people who are married, pregnant, on parental leave, or who have caring responsibilities. Providers of initial education and training will have to give due consideration to our requirements for equality, diversity and fairness (Domain 2). We encourage flexibility in the design and mode of delivery to enable students with caring responsibilities/ requiring parental leave to complete their initial education and training. Modes of delivery should be sufficiently flexible to be delivered in such a way that study, family and other commitments can be balanced. Education and training providers will need to consider when and how student pharmacists would be able to go back on programmes or learning in practice after a period of parental leave. We also ask providers to take into consideration the views of a range of stakeholders, including students, when designing and delivering initial education and training.

6.33 We will consider the feedback raised during the consultation when we amend the proposed standards. The evidence framework will provide clarity for providers about how they can meet our
standards to ensure providers are aware of their responsibilities in the design and delivery of the initial education and training of pharmacists

Race

Observed trends

6.34 Our qualitative analysis undertaken prior to consultation identified some noticeable trends:

- Under half of the pharmacists on our register in May 2019 described themselves as ‘White’ (43%). The second highest group of pharmacists described themselves as ‘Asian’ (37%). Other ethnicities listed were significantly smaller with no figure above 10%.

- Just above half of 2018/19 pre-registration trainees described themselves as ‘Asian’ (53%), whereas a quarter of them defined themselves as ‘White’ (25%) and 13% as ‘Black’.

6.35 In 2014, we commissioned research to understand the less successful performance of Black African registration assessment candidates. Many of the persons interviewed as part of this research were mature students having completed their primary and secondary education overseas, many of them studying on an overseas pharmacist assessment programme. The research showed that belonging to specific ethnic groups, combined with other factors, had an impact on success during studies. The research helped us to identify that:

- Students belonging to minority groups can feel isolated and are less likely to benefit from peer network support (trends that are even more important for mature students who are more likely to have to balance studying with family commitments and financial responsibilities).

- Students who have completed their primary and secondary education overseas can struggle to adapt to UK teaching methods, assessment style and have less confidence to ask questions or request feedback from tutors.

- Overseas students who have a poorer command of the English language can feel hindered during their initial education and training.

- A perceived lack of Black-African role models within the pharmacist education and training pathway to guide can impact the motivation of students of a similar background.

Impact of setting standards for the five years of education and training

6.36 During the consultation, several respondents mentioned that race is strongly linked to socio-economic status and education. They explained that a disproportionately large number of Black, Asian and Minority Ethnic (BAME) people live in poverty in the UK. For them, an increase in the cost of pharmacy education and training would deter BAME applicants.

6.37 Several respondents mentioned that international students who wish to obtain a UK MPharm degree, but not undertake their learning in practice in the UK, might be disadvantaged by the integration of academic and practical learning as this might no longer be an option for them.

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9 Qualitative research into registration assessment performance among Black-African candidates: Report to the GPhC 2016
Impact of our proposed changes for selection and admission

6.38 Many respondents to the consultation survey were concerned that BAME groups and non-British applicants may be disadvantaged during admission procedures. They explained that, if bias was not monitored and controlled during the selection process, these applicants might be negatively impacted by cultural differences. For them, interactive recruitment methods could lead to introducing subjectivity and biases which could negatively impact specific groups if not managed carefully. Several respondents advised that all staff involved in admissions procedures should undertake rigorous cultural training to offset the chance of any unintentional discrimination.

6.39 Other respondents mentioned that raising the academic requirements for entry onto an MPharm degree may negatively impact BAME applicants. Some respondents proposed that all schools of pharmacy should have a minimum intake number for BAME students.

6.40 Other respondents pointed out that English was not the first language of all applicants and students. They were concerned that overseas applicants might be negatively impacted by admission procedures and might struggle with the learning outcomes focusing on communication. However, several respondents were of the opinion that overseas students would significantly improve their English while on the MPharm degree.

Mitigation

6.41 Overall, we believe that potential inequalities for people with this protected characteristic should be mitigated by the introduction of Domain 2 in our proposed standards for providers. It makes specific the importance of integrating equality and diversity into all aspects of pharmacists’ initial education and training and the need to use equality and diversity data to inform course design and delivery, student support and development. These aspects must be taken into account by providers and this is something we focus on in our accreditation and quality assurance processes.

6.42 Our proposal to set standards for the five years of the initial education and training of pharmacists could have a positive impact on reducing the feeling of isolation of students belonging to minority groups. Students would be interacting with health and care professionals as well as with patients and members from the public from an earlier stage. This would enable them to understand their role and build networks. They would also be able to enhance their communication skills earlier on.

6.43 We agree that the financial burden placed on students would be too great and are planning a second phase of stakeholder engagement, which will start in the Autumn 2019, to explore ways in which the integration of academic study and practice learning can be funded.

6.44 In our proposed requirements for the initial educational and training of pharmacists, Domain 1 (selection and admission) requires schools of pharmacy to annually analyse the admission profile of students by protected characteristics, as defined in the Equality Act 2010, and to document actions undertaken if the analysis of the admissions process identifies disadvantages to particular groups of students. Domain 1 also requires that selectors’ training includes equality and diversity awareness.

6.45 We will consider the feedback raised during the consultation when we amend the proposed standards. After we amend the standards for the initial education and training of pharmacists, and they are approved by the GPhC Council, we will develop an evidence framework to support the implementation. This guide will support and assist education and training providers as they implement the standards.
Religion or belief

Observed trends

6.46 Our analysis undertaken prior to consultation identified that of all 2018/19 pre-registration trainees, 36% stated they were Muslim, 26% Christian and 20% stated they did not have a religion.

Taking into consideration the views of patients and members of the public

6.47 We reviewed and consulted on our standards for pharmacy professionals and supporting guidance on religion, personal values and beliefs in 2016/17. Respondents to this consultation highlighted that while pharmacy professionals should not impose their own beliefs on a patient, they should not shy away from discussions where it relates to the person’s care (for example, advice on taking medicines during periods of fasting). Others commented that some patients are sympathetic to the values and beliefs of their professionals, and prefer to see a professional who shares their views. A number of respondents said that patient care could be compromised if a professional felt as though they were being asked to provide services against their conscience.

6.48 Pharmacy professionals need to be aware of, and sensitive to, the many different needs and perspectives of patients. They need to be aware that individual patient reactions to clinical situations can be influenced by their religion or belief, or the strength of their beliefs, and need to be sensitive to cultural, social, religious or spiritual factors, as well as clinical factors.

6.49 A separate equality impact assessment (EIA) was completed for the changes to Standard 1 of the standards for pharmacy professionals. It is important to note that pharmacist students are expected to understand what their responsibilities are once they register as a pharmacy professional. This is reflected into their initial education and training.

Mitigations

6.50 In the proposed revised standards, we strengthened person-centred care, following pre-consultation stakeholder engagement feedback. In particular, Domain 1 of the learning outcomes (person-centred care), is based on Standard 1 of the standards for pharmacy professionals. Students will need to learn the required skills to handle requests for medicines or advice sensitively, and ensure their own religion, personal values or beliefs do not compromise care.

6.51 Domain 2 of the standards ensures that pharmacist students with protected characteristics are not negatively impacted during their initial education and training. Schools of pharmacy must have systems and policies in place to enable staff to understand the diversity of the student body and its implications for course delivery, student support and development. They must also conduct annual reviews of student performance by protected characteristics and to document actions taken to address differences when they are found. To support this, the evidence framework will also provide further information about how equality and diversity must be embedded in course design and delivery.

6.52 In monitoring the impact of the standards, our accreditation, recognition and quality assurance processes requires schools of pharmacy to provide evidence to demonstrate how they apply and meet our standards.
Sex

Observed trends
6.53 Our qualitative analysis undertaken prior to consultation identified that:

• From all 2016/17 first year MPharm students 63% were women and 37% men
• Male pharmacists were more likely to be working in more than one multiple community pharmacy setting\(^ {10}\)
• Male pharmacists were more likely to be working in community pharmacy with four or fewer stores. Women were more likely to be working in a primary care setting or a hospital setting\(^ {11}\)

Impact of setting standards for the five years of education and training
6.54 The majority of pharmacists are women (62% in May 2019). Please refer to the section on pregnancy and maternity for impacts on people who are pregnant, on parental leave and who have caring responsibilities.

Mitigation
6.55 New models of delivery of the initial education and training of pharmacists should not negatively impact students who become pregnant (or parent) during the MPharm degree or learning in practice. Modes of delivery should be sufficiently flexible to be delivered in such a way that study, family and other commitments can be balanced. Education and training providers will need to consider when and how student pharmacists would be able to go back on programmes or learning in practice after a period of parental leave. We have made it clear that our proposed revised standards will support different modes of delivery.

6.56 Domain 2 of our proposed standards states that all aspects of pharmacists’ initial education and training must be based on principles of equality and diversity and respect all relevant legislation. Providers are required to monitor student performance and admissions by the protected characteristics as set out in the Equality Act 2010, proactively address issues and support equality and diversity.

6.57 Our proposed standards also require providers to have systems in place to support students (Domain 7). Education and training providers must be able to demonstrate how they work together to support students in both learning environments.

6.58 We will make sure we address consultation feedback when we amend the standards before they are approved by Council. Implementation will also be monitored through our accreditation and quality assurance processes including considering how our requirements for evidence from course providers that demonstrates how students are supported.

Sexual orientation
6.59 Several consultation respondents felt that Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning or Asexual (LGBTIQA) people are more likely to face a range of negative health experiences and can suffer from mental health problems. They mentioned that previous negative experiences in healthcare settings can prevent patients from disclosing relevant information about

\(^{10}\) The GPhC Registrant survey 2013
\(^{11}\) The GPhC Registrant survey 2013
their sexual orientation or gender identity. They mentioned that the increased focus on person-centred care and improved communication in the standards would benefit LGBTIQA people.

Mitigation

6.60 In the proposed revised standards, we strengthened person-centred care, following pre-consultation stakeholder engagement feedback. In particular, Domain 1 of the learning outcomes (person-centred care), is based on Standard 1 of the standards for pharmacy professionals. Students will need to learn the required skills to handle requests for medicines or advice sensitively, and ensure their own religion, personal values or beliefs do not compromise care.

Welsh language scheme

6.61 A Welsh version of the standards and consultation documents was provided during the consultation to ensure Welsh speaking stakeholders had the opportunity to respond to the consultation.

6.62 We will also provide a Welsh version of the finalised standards and guidance.

Other identified groups

Patients and members of the public

6.63 Many consultation respondents and event participants were of the view that our proposed changes would be beneficial for patients and members of the public as they would receive a higher standard of care.

Students

6.64 A common theme was that our proposed changes would be beneficial for the development of students and would increase the quality of the practice of future pharmacists.

6.65 The main concern of respondents focused on the financial impact of our proposals on students. Respondents were concerned that introducing an integrated degree would mean that students would have to pay for a fifth year of education and training and not receive a salary during their learning in practice. Respondents also anticipated that having several shorter learning in practice placements throughout the five years of initial education and training would mean additional accommodation and travel costs for students. Several respondents worried that international students who wish to obtain a UK MPharm degree, but not undertake their learning in practice in the UK, might decide against studying in the UK.

Schools of pharmacy

6.66 Schools of pharmacy were concerned about the resource and financial impact of our proposed changes. They explained that integration would require them to undertake significant transitions, which would be time and resource-intensive for them. They also anticipated increased costs to change and run their admission procedures; to secure, organise and quality assure experiential learning and learning in practice placements; to appoint and train staff; and to administratively manage programmes. They considered that in the current funding environment it would be hard for them to implement our proposed changes.

Training providers

6.67 Training providers were concerned about the logistics necessary to train students who were at different stages of their initial education and training, at different times and during shorter
placements. They were also unsure about how to work with several schools of pharmacy and worried about the impact of our proposed changes on the workflow of pharmacies. Training providers also mentioned the costs associated with training all staff involved in the supervision of students to a higher standard and increased administrative costs.

6.68 Training providers also explained that the current length of pre-registration placements enables them to train students to their processes and to assess students’ competence before recruiting them. They were concerned that they would no longer be able to do this because of shorter periods of learning in practice.

6.69 Several training providers were also concerned that the introduction of shorter periods of learning in practice would mean that students would look for placements close to where they lived and that this would negatively impact training providers located in less populated and rural areas.

Mitigation

6.70 We acknowledge the financial impacts the integration of academic study and practice learning could have on students, education and training providers. We are currently planning a second phase of stakeholder engagement, which will start in the Autumn 2019, to explore ways in which the integration of academic study and practice learning can be funded. We will also consider the feedback raised during the consultation when we amend the proposed standards.

7. Action needed as a result of the analysis

7.1 We will consider the impacts raised by stakeholders, event participants and survey respondents during the consultation when we modify the proposed standards.

7.2 We will engage on revised standards for selection and admission and on equality, diversity and fairness in the Autumn 2019 before we present them to Council in late 2019/early 2020.

7.3 We will also undertake a phase of stakeholder engagement, which will start in the Autumn 2019, to explore ways in which the integration of academic study and practice learning can be funded.

8. Monitoring and review

8.1 This EIA will be presented to Council at the same time as the consultation analysis report.

8.2 We will consider all issues brought up in this EIA when we amend the proposed standards.

8.3 We will update the EIA when we ask the GPhC Council to approve the finalised standards (in late 2019/early 2020 for the standards on selection and admission and equality, diversity and fairness).

8.4 Once the standards are agreed, courses will be written based on the new standards.

8.5 Our accreditation and quality assurance processes will then allow us to monitor and assess programmes, to ensure they meet our standards.
## Appendix 1: Equality monitoring form – online consultation

### What is your age? Please tick one box

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24 years</td>
<td>5.73%</td>
<td>24</td>
</tr>
<tr>
<td>25-34 years</td>
<td>21.48%</td>
<td>90</td>
</tr>
<tr>
<td>35-44 years</td>
<td>26.01%</td>
<td>109</td>
</tr>
<tr>
<td>45-54 years</td>
<td>19.81%</td>
<td>83</td>
</tr>
<tr>
<td>55-64 years</td>
<td>16.23%</td>
<td>68</td>
</tr>
<tr>
<td>65+ years</td>
<td>4.53%</td>
<td>19</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>6.21%</td>
<td>26</td>
</tr>
</tbody>
</table>

**Analysis**
- Mean: 3.58
- Std. Deviation: 1.54
- Satisfaction Rate: 42.96%
- Variance: 2.36
- Std. Error: 0.08

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<tr>
<th>Response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answered</td>
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</tr>
<tr>
<td>Skipped</td>
<td>18</td>
</tr>
</tbody>
</table>

### Do you consider yourself disabled? Please tick one box

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3.37%</td>
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</tr>
<tr>
<td>No</td>
<td>88.22%</td>
<td>367</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>8.41%</td>
<td>35</td>
</tr>
</tbody>
</table>

**Analysis**
- Mean: 2.05
- Std. Deviation: 0.34
- Satisfaction Rate: 52.52%
- Variance: 0.12
- Std. Error: 0.02

<table>
<thead>
<tr>
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<th>Total</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Skipped</td>
<td>21</td>
</tr>
</tbody>
</table>
What is your ethnic group? Choose the appropriate box to indicate your cultural background. Please tick one box.

<table>
<thead>
<tr>
<th>Response</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>55.40%</td>
<td>231</td>
</tr>
<tr>
<td>Irish</td>
<td>1.92%</td>
<td>8</td>
</tr>
<tr>
<td>Gypsy or Irish traveller</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Other white background (please fill in the box at the end of this section)</td>
<td>5.52%</td>
<td>23</td>
</tr>
<tr>
<td>Caribbean</td>
<td>0.72%</td>
<td>3</td>
</tr>
<tr>
<td>African</td>
<td>3.36%</td>
<td>14</td>
</tr>
<tr>
<td>Other black background (please fill in the box at the end of this section)</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>0.00%</td>
<td>0</td>
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<td>White and Black African</td>
<td>0.24%</td>
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</tr>
<tr>
<td>White and Asian</td>
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<td>Other mixed background (please fill in the box at the end of this section)</td>
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</tr>
<tr>
<td>Bangladeshi</td>
<td>0.72%</td>
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</tr>
<tr>
<td>Other Asian background (please fill in the box at the end of this section)</td>
<td>0.96%</td>
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<tr>
<td>Chinese or Chinese British</td>
<td>2.40%</td>
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<tr>
<td>Arab</td>
<td>0.72%</td>
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<tr>
<td>Other ethnic group background (please fill in the box at the end of this section)</td>
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<tr>
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Analysis

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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Mean</td>
<td>8.06</td>
<td>Std. Deviation:</td>
<td>8.21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Satisfaction Rate:</td>
<td>28.25</td>
</tr>
<tr>
<td></td>
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<td>std. Error:</td>
<td>0.4</td>
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<tr>
<td></td>
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<td>Variance:</td>
<td>67.46</td>
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answered 417  skipped 20
### What is your religion? Please tick one box

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<th>Response Percent</th>
<th>Response Total</th>
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<tbody>
<tr>
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<td>1.21%</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Christian</td>
<td>45.63%</td>
<td>188</td>
</tr>
<tr>
<td>3</td>
<td>Hindu</td>
<td>8.25%</td>
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</tr>
<tr>
<td>4</td>
<td>Jewish</td>
<td>0.73%</td>
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<td>5</td>
<td>Muslim</td>
<td>8.98%</td>
<td>37</td>
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<tr>
<td>6</td>
<td>Sikh</td>
<td>2.18%</td>
<td>9</td>
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<td>7</td>
<td>None</td>
<td>20.63%</td>
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<td>Prefer not to say</td>
<td>9.71%</td>
<td>40</td>
</tr>
<tr>
<td>9</td>
<td>Other</td>
<td>2.67%</td>
<td>11</td>
</tr>
</tbody>
</table>

**Analysis**
- Mean: 4.24
- Std. Deviation: 2.49
- Satisfaction Rate: 40.53

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<table>
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<tbody>
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</table>

### What is your sex? Please tick one box

<table>
<thead>
<tr>
<th></th>
<th>Sex</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>39.38%</td>
<td>165</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>54.42%</td>
<td>228</td>
</tr>
<tr>
<td>3</td>
<td>Other</td>
<td>0.48%</td>
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<tr>
<td>4</td>
<td>Prefer not to say</td>
<td>5.73%</td>
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**Analysis**
- Mean: 1.73
- Std. Deviation: 0.74
- Satisfaction Rate: 24.18

<p>| | | | | |</p>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What is your sexual orientation? Please tick one box

<table>
<thead>
<tr>
<th></th>
<th>Response</th>
<th>Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heterosexual/straight</td>
<td>85.44%</td>
<td>358</td>
</tr>
<tr>
<td>2</td>
<td>Gay woman/lesbian</td>
<td>0.48%</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Gay man</td>
<td>1.67%</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Bisexual</td>
<td>0.72%</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td>0.24%</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Prefer not to say</td>
<td>11.46%</td>
<td>48</td>
</tr>
</tbody>
</table>

Analysis

- Mean: 1.64
- Std. Deviation: 1.62
- Variance: 2.63
- satisfaction Rate: 12.84

Total answered: 419
Total skipped: 18
Analysis of the responses to our consultation on draft guidance for pharmacist prescribers

Purpose

To provide Council with a report on the feedback from the consultation on our draft guidance for pharmacist prescribers

Recommendations

We are currently considering the responses before bringing finalised guidance to Council. In advance of this, the Council is asked to provide feedback on:

a) the analysis of the responses to our discussion paper (Appendix 1) which will be published on our website

b) the Equality Impact Assessment (Appendix 2)

1. Introduction

1.1 The number of pharmacist prescribers has increased, and they are playing a more significant role in providing person centred care. We developed guidance to help pharmacist prescribers provide safe and effective care when prescribing and to help ensure they are meeting our standards. We consulted on draft guidance for pharmacist prescribers for twelve weeks between 29 March and 21 June 2019.

1.2 The draft guidance for pharmacist prescribers reflects the themes of our standards for pharmacy professionals and our standards for registered pharmacies, for consistency, ease of understanding and to ensure patients receive safe and effective care.
1.3 The proposed guidance includes key areas pharmacist prescribers should consider when prescribing to ensure safe and effective care, including:

- taking responsibility for prescribing safely
- keeping up to date and prescribing within their 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

1.4 The guidance also contains information for pharmacy owners and the employers of pharmacist prescribers (section 9).

1.5 There is some overlap between our draft guidance for pharmacist prescribers and our guidance for registered pharmacies providing pharmacy services at a distance, including on the internet, (hereafter referred to as online guidance), which was published in April 2019.

1.6 We used this consultation to test the safeguards for remote prescribing, which were put in the online guidance, in response to feedback from our discussion paper on making sure patients and the public obtain medicines and other pharmacy services safely online (June 2018).

1.7 There may be further changes to the online guidance as a result of our prescribing guidance consultation responses to ensure both documents are aligned and consistent.

2. Key considerations

The GPhC’s strategic objectives

2.1 This consultation is aligned with the following strategic aims:

- to support and improve the delivery of safe, effective care and uphold trust in pharmacy
- to promote patient safety and ensure pharmacy professionals provide safe and effective care
- to assure the public by making sure that pharmacist prescribers have the necessary skills and knowledge.

Consultation, analysis and reporting

2.2 As part of the consultation, we undertook an online survey and patient focus groups in England, Scotland and Wales. We held a roundtable with pharmacy stakeholders and
highlighted the consultation at the Clinical Pharmacy Congress and other relevant events. We also met two other stakeholders to discuss the proposals.

2.3 Our consultation survey asked for views on:
   i. the key areas of the guidance
   ii. the circumstances to consider when it is appropriate to prescribe safely
   iii. prescribing and supplying
   iv. safeguards for remote prescribing of certain categories of medicines, and
   v. the impact this guidance may have on various stakeholder groups

2.4 We received 290 written responses to our main consultation survey, 41 from organisations and 249 from individuals. Over half of the individual respondents were pharmacist prescribers and over three quarters worked in the NHS.

2.5 The consultation analysis report can be found in Appendix 1.

2.6 We have considered every response received, as well as feedback received at stakeholder events. Our thematic approach allows us to fairly represent the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events.

Key findings

General views

2.7 Overall, respondents were supportive of our proposals and were encouraged that guidance would be available in 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.

2.8 In contrast, others were concerned that our proposals could undermine pharmacist prescribers and their ability to use their professional judgement. Many respondents queried how the guidance would apply to pharmacist prescribers working in multi-disciplinary settings such as hospitals.

2.9 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 out of the remit of the independent prescriber altogether.

2.10 Respondents also made suggestions on how our proposals could be strengthened and where further clarity was required.

Views on the key areas for safe and effective prescribing

2.11 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, working in partnership with other healthcare professionals and ensuring that pharmacist prescribers keep up to date with their level of competence.

2.12 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.
2.13 The provisions around prescribing non-surgical cosmetic medicinal products was an area that respondents did not know if the guidance covered the appropriate areas, rather than disagreeing with our proposals.

2.14 Many felt that the key areas in the guidance could be expanded to take into account the practical differences across pharmacy settings, as they felt to guidance was very community-focused.

2.15 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. It was highlighted that our guidance should be consistent with guidance from other organisations.

2.16 Access to records was frequently highlighted by respondents who felt it was important for pharmacist prescribers to have access to the person’s medical records to be able to prescribe safely. However, the limitations of these records were also frequently commented on.

2.17 It was also thought by many that certain aspects of the guidance were open to abuse, for example sharing confidential records across different settings.

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

2.18 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.

2.19 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.

2.20 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

2.21 Our proposals on the circumstances where it may be necessary to prescribe and supply drew a varied response.

2.22 Whilst slightly more 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, out of hours or rural areas and for certain types of conditions e.g. minor ailments and travel vaccinations.

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

2.23 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, compared to those that thought there were.

2.24 There were varied responses and concerns regarding remote prescribing in general. Some respondents also described additional safeguards that the guidance did not already mention. These included more stringent identification checks needed to be put in place when
prescribing remotely, and when prescribing drugs that were open to abuse or misuse such as opioids.

2.25 Some respondents commented how technology led consultations could work safely in practice, such as videoconferencing and video calling. Others thought the guidance focussed too much on online remote prescribing and highlighted that telephone consultations commonly occurred in pharmacist led clinics.

2.26 Many respondents also emphasised the importance of having access to robust medical records when deciding if it was appropriate to prescribe remotely.

2.27 One organisation felt that non-surgical cosmetic products were not suitable for remote prescribing.

**Impact the proposals may have on various stakeholder groups**

2.28 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.

2.29 Many respondents focused on patient safety and felt the guidance would help to raise the standards of pharmacist prescribers more widely, to the benefit of both patients and the public. However, it was thought that pharmacist prescribers and the pharmacy team would be impacted by the increase in workload and demands expected of them.

2.30 In contrast, others thought that the guidance was too restrictive and would make it more difficult for patients to access the medicines they required.

2.31 The majority of respondents 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.

2.32 However, a few respondents believed that there was the potential for individuals or groups with a disability, gender reassignment, pregnancy and maternity and religion or belief to be negatively impacted by our proposals, for example if medicines are not prescribed in a timely manner.

3. **Equality and diversity implications**

3.1 Our equality impact analysis work has been informed by our qualitative and quantitative analysis of responses to the consultation and the available evidence relating to groups by reference to protected characteristics.

3.2 The equality impact analysis in Appendix 2, is to help Council in their decision making regarding the final guidance and about policy proposals. Throughout the development of this work, a detailed analysis of the equality and diversity implications of the proposed changes continues to be updated as any new aspects are identified.

4. **Communications**

4.1 This report will be published on our website.

4.2 The new guidance for pharmacist prescribers is expected to be published in late autumn 2019, subject to council approval.
5. **Resource implications**

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

6. **Risk implications**

6.1 The guidance is closely aligned with our strategic objectives and it is important that it reflects Council’s commitment to recognising the changing roles and valuable contribution of pharmacist prescribers, whilst ensuring the delivery of safe and effective care and services.

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

7. **Monitoring and review**

7. The guidance for pharmacist prescribers, once approved, will be reviewed as and when appropriate.

8. **Next steps**

8.1 We are continuing to work collaboratively with other regulatory agencies, for example, the Medicines and Healthcare products Regulatory Agency (MHRA) and Care Quality Commission (CQC) to help identify issues that affect patient safety, and to make sure pharmacist prescribers provide safe and effective care.

8.2 The key areas we will be focusing on before finalising the guidance are: ensuring the guidance reflects all settings with particular reference to hospitals; access to records; and remote prescribing.

9. **Recommendations**

We are currently considering the responses before bringing finalised guidance to Council. In advance of this, the Council is asked to provide feedback on:

- a) the analysis of the responses to our discussion paper (Appendix 1) which will be published on our website alongside the published guidance
- b) the Equality Impact Assessment (Appendix 2)

Annette Ashley Head of Policy and Standards
General Pharmaceutical Council

05 September 2019
Consultation on guidance for pharmacist prescribers: analysis report

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 an 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

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

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

<table>
<thead>
<tr>
<th>Q2. For each of the nine areas, do you agree or disagree with the guidance we have proposed?</th>
<th>N and % of individuals who agreed</th>
<th>N and % of organisations who agreed</th>
<th>Total N and % of respondents who agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking responsibility for prescribing safely</td>
<td>219 (89%)</td>
<td>24 (65%)</td>
<td>243 (86%)</td>
</tr>
<tr>
<td>Keeping up to date and prescribing within your level of competence</td>
<td>224 (91%)</td>
<td>29 (78%)</td>
<td>253 (89%)</td>
</tr>
<tr>
<td>Working in partnership with other healthcare professionals and people seeking care</td>
<td>225 (91%)</td>
<td>27 (73%)</td>
<td>252 (89%)</td>
</tr>
<tr>
<td>Prescribing in certain circumstances</td>
<td>217 (88%)</td>
<td>25 (68%)</td>
<td>242 (85%)</td>
</tr>
</tbody>
</table>
Q2. For each of the nine areas, do you agree or disagree with the guidance we have proposed?

<table>
<thead>
<tr>
<th>Area</th>
<th>N and % of individuals who agreed</th>
<th>N and % of organisations who agreed</th>
<th>Total N and % of respondents who agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing non-surgical cosmetic medicinal products</td>
<td>156 (63%)</td>
<td>27 (73%)</td>
<td>183 (64%)</td>
</tr>
<tr>
<td>Remote prescribing</td>
<td>179 (72%)</td>
<td>29 (78%)</td>
<td>208 (73%)</td>
</tr>
<tr>
<td>Safeguards for the remote prescribing of certain medicines</td>
<td>184 (74%)</td>
<td>29 (78%)</td>
<td>213 (75%)</td>
</tr>
<tr>
<td>Raising concerns</td>
<td>232 (94%)</td>
<td>32 (86%)</td>
<td>264 (93%)</td>
</tr>
<tr>
<td>Information for pharmacy owners and employers of pharmacist prescribers</td>
<td>182 (74%)</td>
<td>28 (76%)</td>
<td>210 (74%)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Q4. Do you agree or disagree that these are circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?</th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>213 (86%)</td>
<td>29 (78%)</td>
<td>242 (85%)</td>
</tr>
</tbody>
</table>
Q4. Do you agree or disagree that these are circumstances when a pharmacist prescriber must decide whether they can prescribe safely for a person?

<table>
<thead>
<tr>
<th></th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>29 (12%)</td>
<td>6 (16%)</td>
<td>35 (12%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5 (2%)</td>
<td>2 (5%)</td>
<td>7 (2%)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>116 (47%)</td>
<td>20 (54%)</td>
<td>136 (48%)</td>
</tr>
<tr>
<td>No</td>
<td>64 (26%)</td>
<td>13 (35%)</td>
<td>77 (27%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>67 (27%)</td>
<td>4 (11%)</td>
<td>71 (25%)</td>
</tr>
</tbody>
</table>

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
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.

4.4.4. **Other settings**
4.4.5. 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.

4.4.6. 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.

4.4.7. 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.

4.5. **Items prescribed on a regular basis**

4.5.1. 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.

4.5.2. 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.

4.5.3. 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

4.6. **Other issues**

4.6.1. 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.

4.6.2. 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.
4.6.3. A few respondents drew attention to some of the differences in the pharmacy services under the NHS contract across Great Britain, particularly in Scotland.

4.6.4. 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

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

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

<table>
<thead>
<tr>
<th>Q11. What kind of impact do you think our proposals will have on patients and the public?</th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impact</td>
<td>169 (68%)</td>
<td>20 (54%)</td>
<td>189 (67%)</td>
</tr>
<tr>
<td>Negative impact</td>
<td>8 (3%)</td>
<td>1 (3%)</td>
<td>9 (3%)</td>
</tr>
<tr>
<td>Both positive and negative impact</td>
<td>49 (20%)</td>
<td>12 (32%)</td>
<td>61 (21%)</td>
</tr>
<tr>
<td>No impact</td>
<td>15 (6%)</td>
<td>1 (3%)</td>
<td>16 (6%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6 (2%)</td>
<td>3 (8%)</td>
<td>9 (3%)</td>
</tr>
</tbody>
</table>
6.1. 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

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

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

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

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

<table>
<thead>
<tr>
<th>Q14. What kind of impact do you think our proposals will have on employers or pharmacy owners?</th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impact</td>
<td>130 (53%)</td>
<td>13 (35%)</td>
<td>143 (50%)</td>
</tr>
<tr>
<td>Negative impact</td>
<td>18 (7%)</td>
<td>2 (5%)</td>
<td>20 (7%)</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>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?</th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>19 (8%)</td>
<td>1 (3%)</td>
<td>20 (7%)</td>
</tr>
<tr>
<td>Disability</td>
<td>14 (6%)</td>
<td>0 (0%)</td>
<td>14 (5%)</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>11 (4%)</td>
<td>0 (0%)</td>
<td>11 (4%)</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>8 (3%)</td>
<td>0 (0%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>10 (4%)</td>
<td>1 (3%)</td>
<td>11 (4%)</td>
</tr>
<tr>
<td>Race</td>
<td>8 (3%)</td>
<td>0 (0%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>10 (4%)</td>
<td>0 (0%)</td>
<td>10 (4%)</td>
</tr>
<tr>
<td>Sex</td>
<td>2 (&lt;1%)</td>
<td>1 (3%)</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>8 (3%)</td>
<td>0 (0%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>217 (88%)</td>
<td>36 (97%)</td>
<td>253 (89%)</td>
</tr>
</tbody>
</table>

7.1. 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.

7.2. 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%).

---

1 Respondents were asked to tick all that apply
7.3. 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

<table>
<thead>
<tr>
<th>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?</th>
<th>N and % of individuals</th>
<th>N and % of organisations</th>
<th>Total N and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>43 (17%)</td>
<td>2 (5%)</td>
<td>45 (16%)</td>
</tr>
<tr>
<td>Disability</td>
<td>40 (16%)</td>
<td>2 (5%)</td>
<td>42 (15%)</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>29 (12%)</td>
<td>3 (8%)</td>
<td>32 (11%)</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>27 (11%)</td>
<td>3 (8%)</td>
<td>30 (11%)</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>32 (13%)</td>
<td>3 (8%)</td>
<td>35 (12%)</td>
</tr>
<tr>
<td>Race</td>
<td>26 (11%)</td>
<td>2 (5%)</td>
<td>28 (10%)</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>26 (11%)</td>
<td>2 (5%)</td>
<td>28 (10%)</td>
</tr>
<tr>
<td>Sex</td>
<td>31 (13%)</td>
<td>3 (8%)</td>
<td>34 (12%)</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>27 (11%)</td>
<td>3 (8%)</td>
<td>30 (11%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>199 (81%)</td>
<td>34 (92%)</td>
<td>233 (82%)</td>
</tr>
</tbody>
</table>

7.4. 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%).

7.5. 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.

2 Respondents were asked to tick all that apply
7.6. **Summary of the impact that the proposals will have on people sharing particular protected characteristics**

7.6.1. 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.

7.7. **General support**

7.7.1. 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.

7.7.2. 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.

7.8. **Guidance too restrictive**

7.8.1. 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.

7.8.2. 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.

7.8.3. 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.

7.8.4. 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.

7.8.5. 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.

7.8.6. 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 prescribe a medicine could severely impact on those who are pregnant or disabled, for example.

7.9. **No impact**
7.9.1. 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.

7.10. **Other issues**

7.10.1. 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:

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

- **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.

- **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.

- **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

- 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

<table>
<thead>
<tr>
<th>Are you responding: (Base: all respondents)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>As an individual</td>
<td>247</td>
<td>87%</td>
</tr>
<tr>
<td>On behalf of an organisation</td>
<td>37</td>
<td>13%</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>284</td>
<td>100%</td>
</tr>
</tbody>
</table>

Profile of individual respondents

Table 14: Countries

<table>
<thead>
<tr>
<th>Where do you live? (Base: all individuals)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>210</td>
<td>85%</td>
</tr>
<tr>
<td>Scotland</td>
<td>28</td>
<td>11%</td>
</tr>
<tr>
<td>Wales</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>247</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 15: Individual respondent type

<table>
<thead>
<tr>
<th>Are you responding as: (Base: all individuals)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>a pharmacist</td>
<td>227</td>
<td>92%</td>
</tr>
<tr>
<td>a pharmacy technician</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>a pre-registration trainee pharmacist</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>a pharmacy student</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>a member of the public</td>
<td>5</td>
<td>2%</td>
</tr>
</tbody>
</table>
### Table 16: Prescribers

<table>
<thead>
<tr>
<th>Are you responding as: (<em>Base: all individuals</em>)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>other</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>247</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 17: Types of prescribing services

<table>
<thead>
<tr>
<th>What type of prescribing services do you provide? (<em>Base: prescribers</em>)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>113</td>
<td>73%</td>
</tr>
<tr>
<td>Private</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Both NHS and private</td>
<td>17</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Not currently employed in a prescribing role</strong></td>
<td><strong>18</strong></td>
<td><strong>12%</strong></td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>154</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 18: Prescribing remotely

<table>
<thead>
<tr>
<th>Do you prescribe remotely (including online and over the telephone)? (<em>Base: currently employed in prescribing role</em>)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
<td>30%</td>
</tr>
<tr>
<td>No</td>
<td>95</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>136</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 19: Pharmacy owners
### Table 20: Main area of work

<table>
<thead>
<tr>
<th>Area</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community pharmacy</td>
<td>51</td>
<td>21%</td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>89</td>
<td>37%</td>
</tr>
<tr>
<td>Prison pharmacy</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>GP practice</td>
<td>47</td>
<td>20%</td>
</tr>
<tr>
<td>Primary care organisation</td>
<td>19</td>
<td>8%</td>
</tr>
<tr>
<td>Care home</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Pharmaceutical industry</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Research, education or training</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Total N of responses</strong></td>
<td><strong>239</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 21: Size of community pharmacy

<table>
<thead>
<tr>
<th>Size</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent pharmacy (1 pharmacy)</td>
<td>13</td>
<td>25%</td>
</tr>
<tr>
<td>Independent pharmacy chain (2-5 pharmacies)</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Small multiple pharmacy chain (6-25 pharmacies)</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Medium multiple pharmacy chain (26-100 pharmacies)</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Large multiple pharmacy chain (Over 100 pharmacies)</td>
<td>19</td>
<td>37%</td>
</tr>
</tbody>
</table>
Which of the following best describes the community pharmacy you work in? (Base: individuals working in community pharmacy)

<table>
<thead>
<tr>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>100%</td>
</tr>
</tbody>
</table>

Profile of organisational respondents

Table 22: Pharmacy and non-pharmacy organisations

<table>
<thead>
<tr>
<th>Is your organisation: (Base: all organisations)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>a pharmacy organisation</td>
<td>21</td>
<td>57%</td>
</tr>
<tr>
<td>a non-pharmacy organisation</td>
<td>16</td>
<td>43%</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>37</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 23: Type of organisation

<table>
<thead>
<tr>
<th>Please choose the option below which best describes your organisation (Base: all organisations)</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation representing patients or the public</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Organisation representing pharmacy professionals or the pharmacy sector</td>
<td>11</td>
<td>30%</td>
</tr>
<tr>
<td>Independent pharmacy (1 pharmacy)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Independent pharmacy chain (2-5 pharmacies)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Small multiple pharmacy chain (6-25 pharmacies)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Medium multiple pharmacy chain (26-100 pharmacies)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Large multiple pharmacy chain (over 100 pharmacies)</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>NHS organisation or group</td>
<td>11</td>
<td>30%</td>
</tr>
<tr>
<td>Research, education or training organisation</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Government department or organisation</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Regulatory body</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Total N of responses</td>
<td>37</td>
<td>100%</td>
</tr>
</tbody>
</table>
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?
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.
1. Aims and purpose of the project or policy

1.1. This equality impact analysis (EIA) focuses on the equality and diversity implications of proposed new guidance for pharmacist prescribers to ensure they provide safe and effective care in order to give effect to the Public-Sector Equality Duty under section 149 of the Equality Act 2010. To meet Section 149 of the Equality Act 2010 we have due regard to each of the statutory duties:

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

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

1.3. The EIA aims to help ensure that our proposed guidance does not unfairly affect groups with protected characteristics.

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

1.5. In preparing this analysis, we have considered all of the statutory duties under Section 149 of the Equality Act 2010.

1.6. This EIA includes an overview of the work we have completed to inform our understanding of the equality and diversity dimensions of the proposed guidance. We aimed to identify any trends or issues that apply to people who share protected characteristics and considered potential negative impacts on these groups.
1.7. We have updated the analysis throughout the different stages of the policy development process, including pre-consultation, during the consultation and engagement period and post-consultation.

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

1.9. The EIA has been informed by our quantitative and qualitative analysis of responses to the consultation; the available data and/or evidence relating to groups of people with protected characteristics; and engagement with stakeholders at a stakeholder event and patient focus groups held across all three countries (England, Wales and Scotland) during March 2019. The analysis is intended to assist Council in considering whether the In practice: Guidance for pharmacist prescribers should be approved and/or subject to further amendment before introduction.

Policy context

1.10. Pharmacist prescribers play a vital role in the delivery of high-quality healthcare services. Pharmacist prescribers are responsible for creating a culture of person-centred professionalism wherever they work and ensuring prescribing services are delivered safely and effectively.

1.11. Government policies and the changing demands from health services and patients across Great Britain have significantly influenced and developed the role and use of pharmacist prescribers over the last few years. Simultaneously, the number of annotated pharmacist prescribers has significantly increased. While national pharmacy strategies vary across the countries in Great Britain, what is consistent is a recognition that employing pharmacist prescribers across healthcare settings makes the best use of pharmacists’ prescribing knowledge and skills and complements the skills of other members of the healthcare team.

1.12. From time to time, the GPhC publishes guidance to support the 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 to help ensure pharmacist prescribers are meeting our standards.

1.13. 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 to assure the public by making sure that pharmacist prescribers have the necessary knowledge and skills.

1.14. Over the past three years we have carried out 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 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.

1.15. In September 2018, we provided Council with an overview of the regulation of pharmacist prescribing, and the work planned in this area. This included providing guidance for pharmacist prescribers to help ensure patients and the public receive safe and effective care.
1.16. In January 2019 we published revised standards for the education and training of pharmacist independent prescribers. We have recently consulted on our initial education and training for pharmacists revising the learning outcomes so that they are more focused on developing clinical skills and communication skills and making sure that students learn skills relating to prescribing such as consultation and physical examination.

1.17. We have produced 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. It supports the standards for pharmacy professionals which all pharmacy professionals must meet, including pharmacist prescribers regardless of their area of prescribing or scope of practice.

1.18. Standard 1 on person centred-care of our Standards for pharmacy professionals (2017) requires pharmacy professionals to take responsibility for ensuring person centred care is not compromised by personal values and beliefs, including in the context of prescribing. People receive safe and effective care when pharmacy professionals recognise and value diversity and respect cultural differences.

1.19. All pharmacy professionals, including pharmacist prescribers, need to be aware of, and sensitive to, the many different needs and perspectives of people. They need to be aware that individual responses to clinical situations by people can be influenced by their religion or belief, or cultural and social factors, as well as clinical factors.

1.20. We are working collaboratively with other regulatory agencies, for example the MHRA and CQC, to help identify issues that affect patient safety, and to make sure pharmacist prescribers provide safe and effective care.

1.21. We consulted on our proposed guidance between 29 March 2019 and 21 June 2019. We then coded and analysed the consultation responses and incorporated the comments in our revised guidance.

1.22. Once we have finalised the guidance, we will promote the draft guidance to pharmacist prescribers and pharmacy owners and employers of pharmacist prescribers via a range of communication channels, as well as with course providers and awarding bodies to make sure they are aware of our current position.

1.23. In carrying out this analysis, we have considered the potential equality and diversity implications of the proposed pharmacist prescribing guidance.

Legal framework

1.24. The Pharmacy Order 2010 provides powers in relation to publication of guidance and our powers in relation to education and training and acquisition of experience.

1.25. In developing the guidance, we gave due regard to our statutory duties under Section 149 of the Equality Act 2010 and we believe that the proposals align with our over-arching objective which is the protection of the public.

1.26. Overall, we believe that the proposals are fair and justified as good and beneficial for both the people who receive pharmacy services and pharmacist prescribers who will be responsible for meeting the guidance.
2. Review of available information

Developing our evidence-base

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

2.2 Through our evidence gathering we have identified certain areas where it would be beneficial to gather more evidence and data to inform our policy development. As the annotation of prescribers on our register is relatively new, the available data in relation to equality and diversity indicators has been limited.

2.3 We have used the data we gathered through our online survey in response to the equality question.

Pharmacist prescriber data

GPhC commissioned surveys and reports

2.4 We commissioned several pieces of research related to registrants over the past eight years. Some of them, even if it was not their initial focus, included information on prescribing practice. To inform this EIA, we used data from the following reports:

- GPhC Registrant survey 2013\(^1\),
- Prescribers Survey Report (2016)\(^2\).

2.5 The findings of this research are presented alongside our register data (next section) for more clarity and ease of comparison.

2.6 The pieces of research mentioned above were considered during the drafting process for the guidance for pharmacist prescribers, and we sought to ensure a broad range of groups were represented throughout our consultation and engagement process.

General Pharmaceutical Council (GPhC) register data: characteristics of pharmacist independent prescribers in Great Britain

2.7 The information on our register enables us to understand the demographic make-up of the current pharmacist independent prescriber group. On 6th August 2019\(^3\), there were 7,506 annotated independent prescribers, of these pharmacist prescribers, 977 had both independent and supplementary prescribing annotations. There were 313 annotated supplementary prescribers. In total there are 8,796 pharmacist prescribers.

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\(^1\) The GPhC Registrant survey (2013) A total of 29,068 registrants took part in the survey of which 13,730 were pharmacists and 1,823 were pharmacist prescribers.

\(^2\) Prescribers Survey Report (2016)

\(^3\) Obtained from data and insight team-data set extract as of 06.08.19
2.8 Since 2010, the number of annotated pharmacist independent prescribers has steadily increased from 1,545 in 2010 to 7,506 in 2019. In part, this is due to the relative decline in the number of supplementary prescribers, 1,431 in 2011 to 313 in 2019, as all accredited courses for supplementary prescribers stopped by the end of 2009. As it was no longer possible to train as a supplementary prescriber, pharmacists trained as independent prescribers instead, or applied for a conversion course to become independent prescribers.

2.9 There are limits to the data we currently collect on sexual orientation, gender reassignment, marriage/civil partnership, pregnancy/maternity. As a result, we recently modified our Equalities Monitoring Form to collect further protected characteristics data from pharmacist independent prescribers registering with us to address this gap.

2.10 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%.

Age

2.11 44.4 per cent of pharmacist prescribers on our register are aged between 30 and 39 years old and more than a third of the pharmacist prescribers on our register are between 40 and 54 (38.0 per cent).

Table 1: Age of pharmacist prescribers on our register

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Pharmacist prescribers</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-29</td>
<td>775</td>
<td>9%</td>
</tr>
<tr>
<td>30-34</td>
<td>2055</td>
<td>23%</td>
</tr>
<tr>
<td>35-39</td>
<td>1844</td>
<td>21%</td>
</tr>
<tr>
<td>40-44</td>
<td>1482</td>
<td>17%</td>
</tr>
<tr>
<td>45-49</td>
<td>1080</td>
<td>12%</td>
</tr>
<tr>
<td>50-54</td>
<td>780</td>
<td>9%</td>
</tr>
<tr>
<td>55-59</td>
<td>501</td>
<td>6%</td>
</tr>
<tr>
<td>60-64</td>
<td>208</td>
<td>2%</td>
</tr>
</tbody>
</table>

---

4 GPhC Register analysis and 2019 CRM data.
5 GPhC Register analysis, 2011
6 This data and the corresponding table extract is from CRM data as at 06/08/2019. There is data available on the protected characteristic for supplementary prescribers but are focusing on independent prescribers in this EIA as we are no longer accrediting supplementary prescribing courses
2.12 In our registrant’s survey in 2013, of the 1823 pharmacist prescriber respondents, the largest age groups among prescribers who responded were those aged 30-39 (44%) and 40-49 (33%).

2.13 In 2019, the pharmacist independent prescribers on our register aged between 30-49 made up 73 per cent of annotated registrants. This indicates there is a slight decrease in the most predominant age band of our annotated registrants. During our pre-consultation engagement for the IET Standards for PIPs, the education team repeatedly heard that course providers were receiving increased applications from more recent graduates, as opposed to previously where it was predominantly more experienced registrants.

Disability

2.14 In our registrant’s survey in 2013, of the 1823 pharmacist prescriber respondents, one per cent of respondents reported they had a disability.

2.15 In 2019, the proportion of pharmacist independent prescribers on our register who stated they had a disability was less than one per cent. Those that stated they did not have a disability were 32 per cent. However, 68 per cent of pharmacist prescribers on our register did not respond to this question.7

Table 2: Pharmacist prescribers on our register who consider themselves disabled

<table>
<thead>
<tr>
<th>Do you consider yourself to have a disability</th>
<th>Number of pharmacist prescribers</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2828</td>
<td>32%</td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>NULL</td>
<td>5942</td>
<td>68%</td>
</tr>
<tr>
<td>Total</td>
<td>8796</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Race

2.16 In our registrant’s survey in 2013, just over three quarters of prescribers (77%) described themselves as ‘White’ (British and other), three per cent of pharmacist prescribers described themselves as black and 16 per cent as Asian.

7 This data and the corresponding table extract is from CRM data as at 06/08/2019.
2.17 In comparison, in 2019, pharmacist prescribers on our register described themselves as ‘White’ (British, Irish and other) accounted for 58 per cent. In 2019, the pharmacist prescribers who described themselves as ‘Asian’ (Other, Bangladeshi, Indian, Pakistani) accounted for 26 per cent. Only four per cent of pharmacist independent prescribers on our register described themselves as ‘Black’.

Table 3: Race of pharmacist prescribers on our register

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of Pharmacist prescribers</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arab or Arab British</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Asian or Asian British: Bangladeshi</td>
<td>81</td>
<td>1%</td>
</tr>
<tr>
<td>Asian or Asian British: Indian</td>
<td>1333</td>
<td>15%</td>
</tr>
<tr>
<td>Asian or Asian British: Other</td>
<td>211</td>
<td>2%</td>
</tr>
<tr>
<td>Asian or Asian British: Pakistani</td>
<td>703</td>
<td>8%</td>
</tr>
<tr>
<td>Black or Black British: African</td>
<td>376</td>
<td>4%</td>
</tr>
<tr>
<td>Black or Black British: Caribbean</td>
<td>22</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Black or Black British: Other</td>
<td>14</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Chinese or Chinese British</td>
<td>203</td>
<td>2%</td>
</tr>
<tr>
<td>Mixed - Other</td>
<td>44</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Mixed - White and Asian</td>
<td>35</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Mixed - White and Black African</td>
<td>18</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>White - British</td>
<td>145</td>
<td>2%</td>
</tr>
<tr>
<td>White - Irish</td>
<td>589</td>
<td>7%</td>
</tr>
<tr>
<td>White - Other</td>
<td>4349</td>
<td>49%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>181</td>
<td>2%</td>
</tr>
<tr>
<td>Not stated</td>
<td>309</td>
<td>4%</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>182</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>8796</td>
<td>100%</td>
</tr>
</tbody>
</table>

8 This data and the corresponding table extract is from CRM data as at 06/08/2019
Sex (Gender)

2.18 In 2013, pharmacist prescribers who responded were 70% female and 30% male.

2.19 Two thirds of the pharmacist prescribers on our register are women (67%) \(^9\).

2.20 The gender breakdown of pharmacist prescribers has remained relatively stable between those that responded to our registrant’s survey in 2013 and our data extract in 2019.

Table 4: Sex (Gender) of pharmacist prescribers on our register

<table>
<thead>
<tr>
<th>Sex (Gender)</th>
<th>Number of pharmacist prescribers</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>5909</td>
<td>67%</td>
</tr>
<tr>
<td>Male</td>
<td>2887</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>8796</td>
<td>100%</td>
</tr>
</tbody>
</table>

Religion

2.21 In our registrant’s survey in 2013, of the 1823 pharmacist prescriber respondents, 24 per cent of pharmacist prescribers identified as having no religion, 58 per cent as Christian, six per cent as Hindu, seven per cent as Muslim, two per cent as Sikh and one per cent as Jewish.

2.22 In 2019, 71 per cent of the pharmacist prescribers on our register did not respond to this question. From the 29 per cent that did provide their religion, 10 per cent identify as Christians, three per cent as Hindu, eight per cent as Muslim, less than one per cent as Sikh and one per cent stated they did not have a religion\(^10\).

Table 5: Religion of pharmacist prescribers on our register

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number of pharmacist prescribers</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhist</td>
<td>13</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Christian</td>
<td>894</td>
<td>10%</td>
</tr>
<tr>
<td>Hindu</td>
<td>261</td>
<td>3%</td>
</tr>
<tr>
<td>Jewish</td>
<td>8</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Muslim</td>
<td>707</td>
<td>8%</td>
</tr>
</tbody>
</table>

\(^9\) This data and the corresponding table extract is from CRM data as at 06/08/2019.

\(^10\) This data and the corresponding table extract is from CRM data as at 06/08/2019
3. Additional information relevant to equality and diversity issues

3.1 The table below shows that our guidance for pharmacist prescribers is impacted by the relevance to the equality and diversity issues. A full equality impact analysis will need to be carried out.

Table 6: Impact of our guidance for pharmacist prescribers on equality and diversity issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Relevant?</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Marriage or Civil Partnership</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Pregnancy/Maternity</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Welsh Language Scheme</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Other identified groups</td>
<td>☒</td>
<td></td>
</tr>
</tbody>
</table>

4. Decision on impact

4.1 Based on the answers above, does this project or policy require a full impact analysis? This decision takes into account whether this policy or project would result in a substantial change or overall impact for pharmacy.

4.2 If approved, the proposed guidance will apply to all pharmacist prescribers, pharmacy owners and employers, pharmacist prescribers.

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

Other consultation engagement relevant to this EIA

5.1 Before the consultation on the guidance for pharmacist prescribers was launched, we had previously consulted on our initial education and training standards for pharmacist independent prescribers (IET Standards for PIPs) and asked in their pre-consultation whether there were any equality, diversity or inclusion issues raised by our proposals.

5.2 In the IET Standards for PIPs consultation responses, comments received focused on having a strong focus on equality and diversity in the standards and a need for monitoring equality and diversity issues of both pharmacists and training in practice supervisors.

5.3 However, it was agreed during the drafting of the standards that there was a need for further emphasis on equality and diversity within the standards. Therefore, the draft IET standards for pharmacist prescribers emphasise that equality and diversity data should be used actively to inform course design, delivery and trainees’ experience (Domain 2).

5.4 In the consultation no issues were raised in relation to any of the protected characteristics during the stakeholder engagement.

Formal consultation

5.5 We used a wide range of communication activities to maximise participation in the consultation across a diverse range of stakeholder groups, as well as general and targeted engagement approaches to reach all potential audiences. Below is a summary of our extensive consultation and engagement activity:


b. Emails to all registrants and stakeholders with a link to the online survey, concurrent with the launch (potential respondents were invited to respond via an online survey). Hard copy, large font and other language versions of the document were available on request. We received some responses by email.

c. Articles in the GPhC online publication ‘Regulate’

d. Follow up emails to registrants and stakeholders on 06/06/2019.

e. Members of staff on hand to answer any questions throughout the consultation process

f. The consultation was promoted at the Clinical Pharmacy Conference 7-8 June 2019

g. Multiple trade and national press articles relating to the consultation

Patient focus groups

5.6 We held three patient focus groups in London, Cardiff and Glasgow, which allowed us to discuss the consultation questions in depth with patients and the public. Feedback gathered through these groups, who were broadly representative of the British population in terms of age, gender and ethnic background, is not intended to be seen as representing the views of all patients and

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11 https://www.pharmacyregulation.org/previous-consultations#PIP2018
members of the public, but rather a snap shot of a variety of views to inform our work. There were 58 participants.

Pharmacy stakeholder roundtable

5.7 We held one roundtable meeting in London, which was attended by 9 pharmacy stakeholders including representatives from a professional membership body for pharmacists and pharmacy technicians; NHS organisations; community and hospital pharmacy; and other stakeholders.

Date and method of consultation

5.8 The consultation on the draft guidance for pharmacist prescribers was open for 12 weeks (29/3/2019-21/6/2019).

5.9 As part of the consultation survey, we included three questions about equality and diversity (Question 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’, Question 17. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics lists below? Please tick all that apply, and Question 18. Please describe the impact on each of the individuals or groups you have ticked in question 16 and 17.

5.10 We analysed the responses provided by stakeholders to questions 16-18 of the survey. They are integrated in Section 6 of the EIA.

5.11 In total we received:

- 290 written responses, 41 from organisations and 249 from individuals in the survey.
- 154 responses were received from pharmacist prescribers.
- From these 284 responses to the online survey everyone answered this question. 74 respondents provided further comment.
- Overall the majority of respondents thought our proposals would have neither a positive or negative impact on certain individuals or groups who share any of the protected characteristics.
- Of those respondents who thought our proposals would have an impact on certain individuals or groups who share any of the protected characteristics, we have included their views in Section 6 of this equality analysis.

Equality characteristics of consultation respondents

5.12 The equality monitoring questions in the consultation were optional to answer and not compulsory. 154 individual respondents of the 249 who responded to the consultation answered these questions, though not all respondents answered every question. The tables show how many respondents skipped some questions.

5.13 Although 154 pharmacist prescribers responded to the EDI survey, due to the lack of data about how many of the respondents to our equality monitoring questions were pharmacist
prescribers, we cannot draw any conclusions here in relation to how representative the responses are of this group as a whole.

5.14 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%.

**Age**

**Table 7: Age of consultation respondents**

<table>
<thead>
<tr>
<th>What is your age?</th>
<th>Total N of respondents</th>
<th>* Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 16 years</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>16-24 years</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>25-34 years</td>
<td>25</td>
<td>16%</td>
</tr>
<tr>
<td>35-44 years</td>
<td>46</td>
<td>30%</td>
</tr>
<tr>
<td>45-54 years</td>
<td>43</td>
<td>28%</td>
</tr>
<tr>
<td>55-64 years</td>
<td>24</td>
<td>16%</td>
</tr>
<tr>
<td>65+ years</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Not all respondents gave their age

5.15 Table 7 shows that 75% of respondents who responded to the equality monitoring question were between the age of 25 and 54. There was a higher percentage of respondents aged between 35 and 44 years (30%) and 28% were aged between 45-54 years.

**Disability**

**Table 8: Consultation respondents who considered themselves disabled**

<table>
<thead>
<tr>
<th>Do you consider yourself disabled?</th>
<th>Total N of respondents</th>
<th>Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>No</td>
<td>138</td>
<td>90%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>10</td>
<td>6%</td>
</tr>
<tr>
<td>Did not provide a response</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

5.16 As shown in table 8, 3% of respondents to our equality monitoring questions stated they had a disability and 90% stated they did not have a disability.
#### Race

Table 9: Race of consultation respondents

<table>
<thead>
<tr>
<th>What is your race?</th>
<th>Number of respondents</th>
<th>Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>106</td>
<td>69%</td>
</tr>
<tr>
<td>Irish</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Gypsy or Irish traveller</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other white background (please fill in the box at the end of this section)</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>African</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Other black background (please fill in the box at the end of this section)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other mixed background (please fill in the box at the end of this section)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Indian</td>
<td>13</td>
<td>8%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Other Asian background (please fill in the box at the end of this section)</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Arab</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other ethnic group background (please fill in the box at the end of this section)</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td>Did not provide a response</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>100%</td>
</tr>
</tbody>
</table>
5.17 Table 9 shows that 75% of respondents to our equality monitoring form described themselves as ‘White’ (British and other), 12% as ‘Asian’ (Other, Bangladeshi, Indian, Pakistani) and 5% as Black.

Sex (Gender)

Table 10: Sex (Gender) of consultation respondents

<table>
<thead>
<tr>
<th>What is your sex?</th>
<th>Total N of respondents</th>
<th>Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>88</td>
<td>57%</td>
</tr>
<tr>
<td>Male</td>
<td>57</td>
<td>37%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Did not provide a response</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.18 Table 10 shows that 59% of respondents to our equality monitoring questions identified as female, 38% of respondents identified as male and three per cent did not disclose.

Gender Identity

Table 11: Gender identity of consultation respondents

<table>
<thead>
<tr>
<th>Does your gender identity match your sex as registered at birth?</th>
<th>Total N of respondents</th>
<th>Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>142</td>
<td>92%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>8</td>
<td>5%</td>
</tr>
<tr>
<td>Did not provide a response</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.19 We heard from one respondent (<1%) identifying with a gender identity different to their sex as registered at birth, and 5% preferred not to say (table 11).
Sexual Orientation

Table 12: Sexual orientation of consultation respondents

<table>
<thead>
<tr>
<th>What is your sexual orientation?</th>
<th>Total N of respondents</th>
<th>Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual/straight</td>
<td>133</td>
<td>86%</td>
</tr>
<tr>
<td>Gay woman/lesbian</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Gay man</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>16</td>
<td>10%</td>
</tr>
<tr>
<td>Did not provide a response</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

5.20 We heard from a range of respondents who identified themselves as heterosexual (86%), gay (1%), and bisexual/lesbian (<1%) (table 12). Eleven per cent preferred not to say.

Religion

Table 13: Religion of consultation respondents

<table>
<thead>
<tr>
<th>What is your religion?</th>
<th>Total N of respondents</th>
<th>Total % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhist</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Christian</td>
<td>72</td>
<td>47%</td>
</tr>
<tr>
<td>Hindu</td>
<td>8</td>
<td>5%</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Muslim</td>
<td>10</td>
<td>6%</td>
</tr>
<tr>
<td>Sikh</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>None</td>
<td>41</td>
<td>27%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>14</td>
<td>9%</td>
</tr>
</tbody>
</table>
Table 13 shows that 27% of respondents to our equality monitoring questions stated they did not have a religion. From the 62% that did provide their religion, 47% identify as Christians, 6% as Muslim, 5% as Hindu, 1% as Sikh and 9% preferred not to say.

6. Full impact analysis

6.1 We analysed the responses provided by stakeholders to Questions 16, 17 and 18 of the consultation survey. These are integrated in the EIA (full impact assessment in Section 6).

6.2 As part of the consultation survey, we also included a question about the impact of our proposals on pharmacist prescribers, pharmacy owners and employers of pharmacist prescribers, other pharmacy professionals, and people using pharmacy services.

6.3 We have looked at the views where our proposals are thought to have an impact and how to mitigate this where possible.

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

6.5 We have presented below the breakdown of both the positive and negative impact respondents felt our proposed guidance would have on certain individuals or groups who share any of the protected characteristics in the Equality Act 2010. The base number of respondents in table 14 onwards is based on the full consultation respondents (n=284).

Table 14: Positive impact of our proposals on certain individuals or groups who share any of the protected characteristics

<table>
<thead>
<tr>
<th>None of the above – positive impact Responses</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>Total N</td>
</tr>
<tr>
<td>Yes</td>
<td>199</td>
<td>34</td>
<td>233</td>
</tr>
<tr>
<td>No</td>
<td>48</td>
<td>3</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>37</td>
<td>284</td>
</tr>
</tbody>
</table>
6.6 Table 14 shows that 18% of respondents thought our proposals would have a positive impact on any individual or groups sharing any of the protected characteristics in the Equality Act 2010, and 11% thought our proposals would have a negative impact on these groups.

6.7 We asked respondents to tick all the groups of individuals or groups of people who have any of the protected characteristics that they thought would be impacted by our proposals. Below are the results:

**Age**

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

**Table 16: Positive impact on age**

<table>
<thead>
<tr>
<th>Age – positive impact Responses</th>
<th>Individuals</th>
<th></th>
<th>Organisations</th>
<th></th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>Total N</td>
</tr>
<tr>
<td>Yes</td>
<td>43</td>
<td>17%</td>
<td>2</td>
<td>5%</td>
<td>45</td>
</tr>
<tr>
<td>No</td>
<td>204</td>
<td>83%</td>
<td>35</td>
<td>95%</td>
<td>239</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
<td>100%</td>
<td>284</td>
</tr>
</tbody>
</table>

**Table 17: Negative impact of age**

<table>
<thead>
<tr>
<th>Age – negative impact Responses</th>
<th>Individuals</th>
<th></th>
<th>Organisations</th>
<th></th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>Total N</td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>8%</td>
<td>1</td>
<td>3%</td>
<td>20</td>
</tr>
<tr>
<td>No</td>
<td>228</td>
<td>92%</td>
<td>36</td>
<td>97%</td>
<td>264</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
<td>100%</td>
<td>284</td>
</tr>
</tbody>
</table>

6.9 We heard from a range of respondents who felt that people of different ages would be impacted by our proposed guidance for pharmacist prescribers.

6.10 Table 16 shows that 16% of all respondents thought our proposed guidance for pharmacist prescribers would have a positive impact on people of different ages, and seven per cent thought our proposals would have a negative impact.
6.11 One respondent highlighted that elderly people are the group that uses the majority of medicines. They are also the group that may want to access local pharmacies near to their home where they can take advantage of extra services. Another respondent however disagreed and thought that for patients who are elderly, accessing prescriptions from a surgery or a chemist face to face may be challenging, due to mobility issues and that accessing medicines by telephone/internet may be the only option they have and make communication easier. However, another respondent thought that the guidance may make pharmacist prescribers less willing to prescribe for those at extremes of age. It was thought that improved access to medicines and the increased availability of pharmacist prescribers could help the elderly and those with limited mobility to access such services.

6.12 Another respondent suggested that for those without access to remote prescribing (i.e. non-IT users) they would be possibly disadvantaged, and these patients could come from anywhere in society with a possible bias towards the elderly, poor, those with learning difficulties or homeless.

6.13 Several respondents commented on the impact on patients who cannot consent due to age. They thought that while most of the groups of people with protected characteristics can speak for themselves and ask appropriate questions, people who lack capacity are not able to and rely on others eg their Lasting Power of Attorney (LPA) to do this for them. It was suggested that people who have reduced capacity for informed consent may now not be able to have prescriptions written remotely. They also thought that the elderly are often too intimidated to ask and may not know the right questions to ask in relation to themselves.

6.14 The length of time taken to access a patient’s medical record was also raised as an issue that would impact elderly patients, particularly if there were not seats available which may cause the pharmacy team and patient to become stressed, and there wasn’t another pharmacist available to help with this. (This point was raised by this respondent in relation to disabled people and pregnant women. It has only been included here to avoid repetition.)

6.15 It was also thought that the additional safeguards might hinder/delay prescribing by some pharmacists who may need to brush up on their competencies or ability to prescribe was also cited as having a negative impact on people of all groups.

6.16 It was pointed out that older people are more vulnerable and therefore more likely to be at risk. Another respondent thought that as a result of our proposals elderly patients would get better polypharmacy reviews.

6.17 One respondent thought that some older or housebound patients may be slightly disadvantaged on implementation of this guidance, but this would revert the workload back to the appropriate person, eg the GP. They did however feel it would be positive for some.

6.18 One organisation commented that our proposals said pharmacist prescribers should consider the risks when prescribing for different groups of patients (for example babies, children, young people, women and girls able to have children, pregnant and lactating women and older people). They questioned why these groups of people (including some with protected characteristics) were included and suggested that we should add the rationale as to why they were specifically
acknowledged. They highlighted as an example, the different pharmacodynamics/pharmacokinetic effects of medicines on children.

6.19 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to age.

6.20 Equality and diversity are embedded in the standards for pharmacy professionals. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the person their first priority. As new roles are emerging, and different pharmacy services provided in different ways, people of different ages will have a greater choice of how they access their medicines. We published a Regulate article Focus on delivering person-centred care for older people which helps pharmacy professionals understand the issues relevant to this group of people.

6.21 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Disability**

6.22 People with disabilities face many barriers in accessing healthcare. As part of the feedback we have sought to assess the impact of our proposals on people with disabilities.

**Table 18: Positive impact on disability**

<table>
<thead>
<tr>
<th>Disability – positive impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>40</td>
<td>16%</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>207</td>
<td>84%</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
</tr>
</tbody>
</table>

**Table 19: Negative impact on disability**

<table>
<thead>
<tr>
<th>Disability – negative impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>6%</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>233</td>
<td>94%</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
</tr>
</tbody>
</table>

6.23 We heard from a range of respondents who felt that people with a disability would be impacted by our proposed guidance for pharmacist prescribers.

6.24 Table 18 shows, 15% of all respondents thought our proposed guidance for pharmacist prescribers would have a positive impact on people with a disability. Five per cent thought our proposals would have a negative impact.
6.25 Improved access to medicines by disabled people was thought by several respondents to be beneficial as they may not be able to access 'traditional' avenues to obtain medication for lifestyle conditions and that online/remote prescribing would be appropriate for them. It was also thought that disabled people may find it easier to have a video call with their health professional, rather than having to plan a journey into see their healthcare provider, which can sometimes be costly and inconvenient. Some respondents thought that the increased availability of pharmacist prescribers which will emerge due to the guidance would help those with limited mobility to access such services.

6.26 Reduced access to medicines was highlighted by a few respondents, as they thought the guidance was unnecessarily restrictive and pharmacist prescribers would not prescribe for disabled people and there would be a reduced ability to remotely monitor these patients. It was also felt that some of the requirements of the guidance would increase the waiting time for elderly patients who may be vulnerable or had other disabilities such as hearing impairment.

6.27 Another respondent pointed out that there could be a negative impact on patients who are deaf and dumb, and suggested that a trained sign language person may need to be in all premises.

6.28 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.

6.29 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to disability.

6.30 Equality and diversity are embedded in the standards for pharmacy professionals. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the person their first priority. As new roles are emerging, and different pharmacy services provided in different ways, people with disabilities will have a greater choice of how they access their medicines.

6.31 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Sex (Gender)**

6.32 We heard from a range of respondents who thought that people of different sex would be impacted by our proposed guidance for pharmacist prescribers.

**Table 20: Positive impact on sex (gender)**

<table>
<thead>
<tr>
<th>Sex – positive impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
<td>13%</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>216</td>
<td>87%</td>
<td>34</td>
</tr>
</tbody>
</table>
Table 21: Negative impact on sex (gender)

<table>
<thead>
<tr>
<th>Sex – negative impact Responses</th>
<th>Individuals N</th>
<th>Individuals %</th>
<th>Organisations N</th>
<th>Organisations %</th>
<th>All respondents Total N</th>
<th>All respondents Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>1%</td>
<td>1</td>
<td>3%</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>No</td>
<td>245</td>
<td>99%</td>
<td>36</td>
<td>97%</td>
<td>281</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>247</strong></td>
<td><strong>100%</strong></td>
<td><strong>37</strong></td>
<td><strong>100%</strong></td>
<td><strong>284</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

6.33 As shown in Table 20, 12% of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on people of different sexes, and one per cent thought our proposals would have a negative impact.

6.34 One respondent thought that females may have easier access to contraception options by using an independent prescriber.

6.35 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to sex (gender).

6.36 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Gender reassignment**

6.37 We heard from a range of respondents who felt that people who were undergoing or who had completed gender reassignment would be impacted by our proposed guidance for pharmacist prescribers.

Table 22: Positive impact on gender reassignment

<table>
<thead>
<tr>
<th>Gender reassignment – positive impact Responses</th>
<th>Individuals N</th>
<th>Individuals %</th>
<th>Organisations N</th>
<th>Organisations %</th>
<th>All respondents Total N</th>
<th>All respondents Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29</td>
<td>12%</td>
<td>3</td>
<td>8%</td>
<td>32</td>
<td>11%</td>
</tr>
<tr>
<td>No</td>
<td>218</td>
<td>88%</td>
<td>34</td>
<td>92%</td>
<td>252</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>247</strong></td>
<td><strong>100%</strong></td>
<td><strong>37</strong></td>
<td><strong>100%</strong></td>
<td><strong>284</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 23: Negative impact on gender reassignment

<table>
<thead>
<tr>
<th>Gender reassignment – negative impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>-----------</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>236</td>
<td>96%</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
</tr>
</tbody>
</table>

6.38 Table 22 shows that 11% of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on people who were undergoing or who had completed gender reassignment, and four per cent thought our proposals would have a negative impact.

6.39 Regarding prescribing safely, one organisation highlighted, *that the person must be asked if they are taking any medicines that may not be on their medical records, for example medication purchased online. For example, a trans person may be self-medicating with hormones bought online. They may be anxious about disclosing this information. It was pointed out that by being clear what is going to be done with this information (if anything) would be helpful. It was also highlighted that pharmacists should not make assumptions around patient’s gender identity or trans status and should aim to keep questions about medication broad e.g. it must not be ruled out that someone presenting as male could be taking the contraceptive pill. Therefore, it would be best to ask people ‘are you taking any medication?’ rather than assuming the person will definitely be taking certain medications.*

6.40 Regarding safeguards for prescribing remotely the same organisation highlighted that patients can change their name and gender marker with their GPs so if pharmacists are going to check ID they should be aware that the name on a patient’s medical record may not match the name on their ID or which gender they are currently identifying with. It was suggested that pharmacists should make patients aware, at the start of the consultation, that any information they disclose could be shared with their GP and other relevant healthcare professionals. Providing examples of information that could be shared will help patients understand their rights regarding confidentiality and disclosure.

6.41 *The same organisation who thought the proposals would not negatively impact patients, suggested that for maximum impact and person-centred care pharmacists should recognise the diverse needs and identities of their patients, the specific health needs of LGBT people and the importance of informed consent including understanding confidentiality and sharing information.*

6.42 One respondent thought that pharmacists would be reluctant to prescribe for patients who are transgender, limiting their access to medicines, but did not give a reason why.

6.43 One respondent suggested that pharmacist prescribers may be encouraged to prescribe inappropriately for patient who want gender reassignment therapy, as it could potentially be done online.

6.44 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to gender reassignment.

6.45 Equality and diversity are embedded in the standards for pharmacy professionals. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and
then adapt the care to meet their needs. This might include addressing the specific needs of people from LGBT and other communities. We published a Regulate article *Focus on pride in practice* which helps pharmacy professionals understand the issues relevant to this group of people.

6.46 We will consider these comments in the redrafting of the guidance.

6.47 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Marriage or Civil Partnership**

6.48 Through the equality and diversity question in the survey, we heard from a range of respondents who felt that people who were married or in a civil partnership would be impacted by our proposed guidance for pharmacist prescribers.

Table 24: Positive impact on marriage and civil partnership

<table>
<thead>
<tr>
<th>Marriage and civil partnership – positive impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>27</td>
<td>11%</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>220</td>
<td>89%</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
</tr>
</tbody>
</table>

Table 25: Negative impact on marriage and civil partnership

<table>
<thead>
<tr>
<th>Marriage and civil partnership – negative impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>3%</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>239</td>
<td>97%</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
</tr>
</tbody>
</table>

6.49 As shown in Table 24, 11% of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on married people or people in a civil partnership. Three per cent thought our proposals would have a negative impact on this group of people.

6.50 One respondent highlighted that patients who are married or in civil partnerships may not wish for their GP to be notified in fear of being found out that they are obtaining certain lifestyle medications. Patients should be able to obtain their medication in a discreet, safe manner.

6.51 Another respondent thought there could be issues between partners if their details were found out through online accounts.
6.52 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to marriage and civil partnership.

6.53 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Pregnancy/maternity**

6.54 We heard from a range of respondents who felt that people who were pregnant and those on maternity leave would be impacted by our proposed guidance for pharmacist prescribers.

### Table 26: Positive impact on pregnancy and maternity

<table>
<thead>
<tr>
<th>Pregnancy and maternity – positive impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>32</td>
<td>13%</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>215</td>
<td>87%</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>247</strong></td>
<td><strong>100%</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>

6.55 Table 26 shows that 12% of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on pregnant women and those on maternity leave, and four per cent thought our proposals would have a negative impact.

6.56 Several respondents felt that prescribing by pharmacist prescribers for these groups should be safer due to this guidance.

6.57 The length of time taken to access a patient’s medical record was also raised as an issue that would impact pregnant patients, particularly if there were not seats available which may cause the pharmacy team and patient to become stressed.

6.58 There were differing views on access to medicines by pregnant patients. Improved access to medicines was also raised as a positive impact for pregnant patients and those with young babies. One respondent felt that the number of young pregnancies could be reduced, as they would have greater access to contraception without being faced with judgmental attitudes. Another
respondent disagreed with this and felt there would be a negative impact on access to sensitive areas such as contraception, PrEP and PEP.

6.59 However, other respondents felt that there would be a negative impact on pregnant women as pharmacist prescribers may be reluctant to prescribe for them or receive appropriate prescribing. They felt this was because community pharmacists are unhappy to prescribe for pregnant and post-partum patients outside the medicines licensing, and also unaware of additional resources for information, as demonstrated by medication advice audits.

6.60 One organisation commented that our proposals said pharmacist prescribers should consider the risks when prescribing for different groups of patients (for example babies, children, young people, women and girls able to have children, pregnant and lactating women and older people). They questioned why these groups of people (including some with protected characteristics) were included and suggested that we should add the rationale as to why they were specifically acknowledged. They highlighted as an example, the different pharmacodynamics/pharmacokinetic effects of medicines on children.

6.61 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to pregnancy and maternity.

6.62 Equality and diversity are embedded in the standards for pharmacy professionals. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs.

6.63 We will consider these comments in the redrafting of the guidance

6.64 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

Race

6.65 We heard from a range of respondents who felt that people of different races would be impacted by our proposed guidance for pharmacist prescribers.

**Table 28: Positive impact on race**

<table>
<thead>
<tr>
<th>Race – positive impact Responses</th>
<th>Individuals</th>
<th></th>
<th>Organisations</th>
<th></th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>Total N</td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>11%</td>
<td>2</td>
<td>5%</td>
<td>28</td>
</tr>
<tr>
<td>No</td>
<td>221</td>
<td>89%</td>
<td>35</td>
<td>95%</td>
<td>256</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
<td>100%</td>
<td>284</td>
</tr>
</tbody>
</table>

**Table 29: Negative impact on race**

<table>
<thead>
<tr>
<th>Race – negative impact Responses</th>
<th>Individuals</th>
<th></th>
<th>Organisations</th>
<th></th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>Total N</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
<td>37</td>
<td>100%</td>
<td>284</td>
</tr>
</tbody>
</table>
6.66 As shown in Table 28, 10% of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on people of different races, and three per cent thought our proposals would have a negative impact.

6.67 One respondent thought that race may be impacted by our proposals but provided no details of the way this would occur.

6.68 Another aspect highlighted under race was the possible negative impact on patients who cannot speak or understand English very well.

6.69 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to race.

6.70 Equality and diversity are embedded in the standards for pharmacy professionals. In providing person centred care we expect pharmacist prescribers to give the person all relevant information in a way they can understand, so they can make informed decisions and choices.

6.71 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Religion or belief**

6.72 We heard from a range of respondents, who felt that people with a religious belief would be impacted by our proposed guidance for pharmacist prescribers.

**Table 30: Positive impact on religion or belief**

| Religion or belief – positive impact | Individuals | | | Organisations | | | All respondents |
|---|---|---|---|---|---|---|
| | N | % | | N | % | | Total N | Total % |
| Yes | 26 | 11% | | 2 | 5% | | 28 | 10% |
| No | 221 | 89% | | 35 | 95% | | 256 | 90% |
| Total | 247 | 100% | | 37 | 100% | | 284 | 100% |

**Table 31: Negative impact on religion or belief**

| Religion or belief – negative impact | Individuals | | | Organisations | | | All respondents |
|---|---|---|---|---|---|---|
| | N | % | | N | % | | Total N | Total % |
| Yes | 10 | 4% | | 0 | 0% | | 10 | 4% |
| No | 237 | 96% | | 37 | 100% | | 274 | 96% |
| Total | 247 | 100% | | 37 | 100% | | 284 | 100% |
6.73 Table 30 shows that 10% of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on people with a religion or having no religion, and four per cent thought our proposals would have a negative impact.

6.74 A few individual respondents highlighted the impact the religious beliefs of the pharmacist prescriber may have on people. It was felt that there was no reason any of these groups should be affected as long as the pharmacist involved put their personal feelings aside and did not let their religious beliefs affect the clinical judgement. One respondent thought that pharmacists with certain religion/belief may not be able to comply with the guidance, and someone else thought there would always be issues around religion and sex, for example the supply of emergency hormonal contraception.

6.75 One organisation was concerned that our guidance would make it difficult for a pharmacist prescriber who held a religious belief to prescribe. They felt that the guidance failed to include any mention of the pharmacist’s freedom not to prescribe on the grounds of conscience, a freedom which they said was already recognised in our Guidance on religion, personal values and beliefs.

6.76 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to religion.

6.77 Equality and diversity are embedded in the standards for pharmacy professionals. In providing person centred care we expect pharmacist prescribers to recognise their own values and beliefs but do not impose them on other people and take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs. Our guidance on religion, personal values and beliefs helps pharmacy professionals understand what it means to take responsibility for ensuring person centred care is not compromised.

6.78 We will further consider this as we redraft the guidance to make it clear that our guidance on religion, personal values and beliefs applies to pharmacists when they are prescribers.

6.79 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Sexual orientation**

6.80 We heard from a range of respondents, who thought that people of differing sexual orientation would be impacted by our guidance for pharmacist prescribers.

<table>
<thead>
<tr>
<th>Table 32: Positive impact on sexual orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual orientation – positive impact Responses</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
The table below shows the negative impact on sexual orientation:

<table>
<thead>
<tr>
<th>Sexual orientation – negative impact</th>
<th>Individuals</th>
<th>Organisations</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>3%</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>239</td>
<td>97%</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>247</td>
<td>100%</td>
<td>37</td>
</tr>
</tbody>
</table>

6.81 Eleven per cent of all respondents thought our proposals for guidance for pharmacist prescribers would have a positive impact on certain individuals or groups who have any of the protected characteristics, (Table 32) and three per cent thought our proposals would have a negative impact, (Table 33)

6.82 One respondent considered that any guidance which is designed to promote good practice should have a positive effect on everybody it affects because it will be protecting them from harm. They thought patients may not feel it has a positive impact if it prevents them from obtaining medication they think they need but patient safety is important, whatever their situation or orientation.

6.83 Another respondent thought that the new proposals would not negatively impact patients. However, they highlighted that for maximum impact and person-centred care, pharmacists should recognise the diverse needs and identities of their patients, the specific health needs of LGBT people and the importance of informed consent including understanding confidentiality and sharing information.

6.84 We are aware that with limited data we cannot fully assess whether our proposals are likely to have differing impacts in relation to sexual orientation.

6.85 Equality and diversity are embedded in the standards for pharmacy professionals. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs. (See section 6.54 for how we have mitigated against this.)

6.86 We will monitor feedback during implementation to ensure that no negative impacts arise that have not been identified and need to be mitigated in the future.

**Other equalities related issues**

6.87 We have also considered the following equality related issues.

**Workplace pressures and the pharmacy team**
6.88 Some respondents highlighted the potential negative impact of the changes on workplace pressures and the pharmacy team.

6.89 One organisation felt it would increase the burden and the work involved by requiring extra checks to be made and contacting the GP regarding patients.

6.90 Another organisation thought staff capacity would be affected while another organisation felt that team working would be impacted.

6.91 We will consider these issues as we redraft the guidance and continue our work on professionalism under pressure across the organisation. This includes the inspection team looking out for workplace pressures when inspecting pharmacies.

**Different working environments**

6.92 We are aware that pharmacist prescribers are working in emerging roles and government policies are changing and prescribing roles can be very different.

6.93 In our 2016 prescribing survey report we asked pharmacist prescribers what types of settings they had worked in as a pharmacist prescriber.

*Table 34: Different work settings of pharmacist prescribers in our 2016 prescribing survey*

<table>
<thead>
<tr>
<th>Work setting</th>
<th>Total %T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>46%</td>
</tr>
<tr>
<td>GP practice</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
<tr>
<td>Primary care organisation</td>
<td>8%</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>8%</td>
</tr>
<tr>
<td>Care home</td>
<td>1%</td>
</tr>
<tr>
<td>Prison</td>
<td>1%</td>
</tr>
<tr>
<td>Education/training</td>
<td>0%</td>
</tr>
</tbody>
</table>

6.94 In 2019, respondents to our consultation who were pharmacist prescribers indicated the areas in which they worked:
Table 35: Different work settings of pharmacist prescribers from our prescribing guidance consultation

<table>
<thead>
<tr>
<th>Work setting</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital pharmacy</td>
<td>45%</td>
</tr>
<tr>
<td>GP practice</td>
<td>28%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
<tr>
<td>Primary care organisation</td>
<td>9%</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>8%</td>
</tr>
<tr>
<td>Care home</td>
<td>1%</td>
</tr>
<tr>
<td>Prison pharmacy</td>
<td>1%</td>
</tr>
<tr>
<td>Research, education or training</td>
<td>3%</td>
</tr>
</tbody>
</table>

6.95 The number of pharmacist prescriber who responded, and the areas they indicated they worked in is consistent with our prescriber’s survey from 2013.

6.96 Respondents highlighted that hospital pharmacies and other environments were not clearly included in the guidance.

6.97 Our research and consultation responses to the initial education and training standards for pharmacy technicians underlined differences in training in community and hospital pharmacies.

6.98 We will make sure in redrafting the guidance that working in different contexts is considered.

Other places

6.99 Several respondents suggested that there would be an impact on people who live in remote or rural geographical locations, for example the Scottish Highlands and islands or rural areas in Wales where no other access to medicines is practical or readily accessible. It was felt that it was essential that pharmacist prescribers are not prevented from acting in the best interests of the patients.

6.100 In our pre-consultation engagement, we piloted the questions we were asking in the prescribing guidance consultation and received feedback. One assessor highlighted that the explanatory text regarding a proposed question could relate to the homeless population, but the person may not have a protected characteristic under the Equality Act 2010. They felt this population needed to be considered as they felt our questions (16 and 17) were too narrow focusing solely on protected characteristics and would impact on true equality of access to medicines.

6.101 One organisation suggested that our proposals should be expanded to take into consideration prescribing for the homeless and those on the streets with no fixed abode. They also thought that prisoners may find the guidance to be restrictive.
6.102 We will consider these issues in the redrafting of our guidance to make sure homeless people will not be negatively impacted by our proposals.

**Welsh language scheme**

6.103 A Welsh version of our guidance and consultation document was published. This ensured that Welsh speaking stakeholders had the opportunity to provide input.

6.104 We will also provide a Welsh version of the finalised guidance.

**7. Action needed as a result of the analysis**

Equality and diversity are embedded in the standards for pharmacy professionals. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs.

Our analysis indicates that we need to continue to consider the equality and diversity issues raised in this analysis, as we redraft the guidance for pharmacist prescribers.

**8. Monitoring and review**

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

This analysis is intended to assist Council in considering whether the proposed guidance for pharmacist prescribers should be approved and/or subject to further amendment before introduction.

We will continue to consider how feedback is incorporated into evidence gathering and ensure we have appropriate mechanisms in place to monitor any other equality concerns that emerge and how we will mitigate against them.

We will continue to assess through our inspections whether pharmacist prescribers are prescribing safely to ensure safe and effective care.

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

The results from the consultation have informed the draft guidance.

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

c) What is the timetable for monitoring, including key dates?

The guidance will be reviewed, as and when appropriate or when there are significant changes in prescribing practice.

**9. Summary of the analysis of the effects on equality**

This section sets out what action will be taken as a result of the analysis.

No impact identified: no change to the policy or project
The reasons for this decision are:
The Council will be considering the responses to the consultation held between March 2019 and June 2019 in making its decision, as described in the consultation analysis report and the EIA. Part of the consultation analysis included a review of three questions designed to gather information about the impact of our proposals on individuals or groups who share protected characteristics and any other impacted individuals or groups. This information was used to update a full equality impact analysis.

Overall there was a general positive support for the proposals, with a small percentage of respondents feeling there would be a negative impact across all the groups. A minority of respondents felt that there would be negative impacts on groups and individuals that we asked about – including patients and the public, pharmacy professionals, employers and pharmacy owners, and groups and individuals sharing any of the protected characteristics.

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%). This means that the impact of our prescribing guidance more generally may be greater on some individuals or groups who share protected characteristics.

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 of what was expected of them. This is a key time to make the patients and public aware of the changing roles of pharmacist prescribers and the impact they can have on patient’s safe access to medicines.

There was some concern that our proposals could undermine pharmacist prescribers and their ability to use their professional judgement. Many respondents queried how the guidance would apply to pharmacist prescribers working in multi-disciplinary settings such as hospitals, where consent was not always clear. Our guidance will clarify this and also what we expect of pharmacist prescribers who prescribe remotely to ensure patient safety.

Considering the steps mentioned above, we are confident that we can mitigate any unintended negative impacts of the guidance for pharmacist prescribers. We will do this by regularly reviewing and monitoring the effectiveness of this guidance. We will also be working with the GPhC’s Equality, Diversity and Inclusion (EDI) Leadership group to update and review this equality impact analysis, as and when appropriate.
Meeting paper

Council on Thursday, 12 September 2019

Public business

Reporting on the June 2019 Registration Assessment

Purpose
To update Council on candidate performance in the June 2019 Registration Assessment.

Recommendations
Council is asked to note:

i. candidate performance data (Appendix 1); and
ii. the Board of Assessors’ report to Council (Appendix 2) and the assurance it provides about the June 2019 sitting.

1. Introduction

1.1 Passing the GPhC’s Registration Assessment is a pre-requisite for applying to register as a pharmacist. There are two sittings every year, in June and September. This paper discusses the June 2019 sitting.

1.2 Responsibility for the Registration Assessment is split between the GPhC and the Board of Assessors (the ‘Board’). The Board sets and moderates the Assessment and agrees reasonable adjustments for candidates with specific needs; the GPhC is responsible for operational matters, including registration, venues, invigilation and printing. The Registration Assessment papers are developed by experienced pharmacists and assessment experts. Questions are written by practising pharmacists, then the standard of each question is set by standards setters, all of whom are practising pharmacists with current knowledge of pre-registration trainees and/or recently registered pharmacists.

1.3 Papers are then set by an appointed body of pharmacists and assessment experts, the Board of Assessors. Without exception, all questions and papers are mapped on to the GPhC’s Registration Assessment Framework to ensure they reflect the practice of a day one pharmacist.
1.4 After a sitting, the performance of all questions and papers are analysed and, using statistical methods applied across health professional examinations, the pass mark for each paper is confirmed and candidates are awarded passes or fails. Candidates who pass both papers pass overall.

1.5 2942 candidates sat the assessment in June with 2128 passing – a pass rate of 72.3%. This compares with a pass rate of 79% in 2018.

2. Feedback from candidates

2.1 The British Pharmaceutical Students’ Association (BPSA) produces a report after the assessment based on feedback from candidates. We held a constructive meeting with them to go through their recommendations. Many of these relate to specific operational matters such as desk space, signage and temperature at the venues and reflect similar matters raised in previous years by candidates. We will consider all the recommendations carefully and, where necessary, discuss issues with the relevant venues prior to future sittings of the assessment and consider whether we need to provide any additional information for candidates in future.

3. The pass rate and publication of performance data

3.1 Data releases: All candidate performance data releases comply with the EU’s General Data Protection Regulation (2016, implemented 2018) and the Freedom of Information Act 2000. As a general principle we release as much data as possible while ensuring that what is presented preserves the anonymity of individuals. This means that some data are not reported. As well as the data presented in this paper, in several weeks there will be a further data release of (1) performance by pre-registration training provider and (2) an anonymised list of candidate results.

3.2 Candidate pass lists: In previous years the GPhC has issued candidate pass lists on its website but has decided to discontinue doing so, to ensure that candidates have full control over who is informed whether they have passed the Registration Assessment or not.

3.3 The pass rate: As the Board has noted at 4.4 in its report to Council, the spread of pass rates by school of pharmacy is wide for the June sitting. Having undertaken further analysis, the effect of cohorts from the five schools with pass rates <65% on the overall pass rate is as follows:
### Candidate category

<table>
<thead>
<tr>
<th>Pass rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall pass rate for MPharm 1&lt;sup&gt;st&lt;/sup&gt; attempt candidates (NB Not including OSPAP candidates)</td>
</tr>
<tr>
<td>Pass rate for MPharm 1&lt;sup&gt;st&lt;/sup&gt; attempt candidates from the five schools with pass rates &lt;65%</td>
</tr>
<tr>
<td>Pass rate for MPharm 1&lt;sup&gt;st&lt;/sup&gt; attempt candidates excluding the five schools with pass rates &lt;65%</td>
</tr>
</tbody>
</table>

3.4 This means that the candidate cohorts from the five schools with pass rates <65% have lowered the overall pass rate for MPharm 1<sup>st</sup> attempt candidates by 5.57%.

3.5 We note that the group of schools with comparatively low cohort pass rates has not changed significantly in the last few years. While there can be several factors affecting individual performance, including the experience in the pre-registration year, we do believe this requires further investigation and will be meeting the five schools in the next few weeks to hear their views on the reason for the lower performance.

### 4. Equality and diversity implications

4.1 After every sitting we produce analyses of candidate performance by characteristic (Appendix 1) to assist schools of pharmacy, reregistration training providers and other stakeholders in their understanding of pharmacist IET from the perspective of the Registration Assessment. We will continue to use these data as we refine the IET standards currently under review and will use them to frame conversations with stakeholders about the proposed changes to our standards.

4.2 In common with every sitting, our Adjustments panel considered and granted adjustments for candidates with specific (learning) needs. After an increase over several years, adjustment requests seem to have plateaued (as has the number of candidates): 215 adjustment requests were granted for the June sitting, compared with 207 in June 2018 and 183 in June 2017. As with most sittings, requests for extra time to accommodate dyslexia/dyspraxia/anxiety were most common.

4.3 More generally, our recent consultation on initial education and training standards for pharmacists proposed a strengthening of our current requirements. In particular, a requirement for providers to carry out every year a review of student performance and admissions using the protected characteristics defined by the Equality Act 2010 and to demonstrate the actions they have taken to examine the reasons for any differences in achievement.
5. Communications
5.1 The pass rate and other information was published on our website on 26 July.

6. Resource implications
6.1 There are no additional resource implications for the GPhC arising from this paper.

7. Risk implications
7.1 As highlighted, we are meeting the schools with comparatively low pass rates to identify relevant issues.

8. Monitoring and review
8.1 The Registration Assessment is reviewed after every sitting by the GPhC and Board of Assessors. The Board reports on each sitting to Council and the chair attends Council once a year to discuss the year’s sittings.

Recommendations
Council is asked to note:
   i. candidate performance data (Appendix 1); and
   ii. the Board of Assessors’ report to Council (Appendix 2) and the assurance it provides about the June 2019 sitting.

Damian Day, Head of Education
General Pharmaceutical Council

damian.day@pharmacyregulation.org

30 August 2018
Appendix 1

June 2019 Registration Assessment performance breakdown by characteristic

Table 1a: Overall performance

<table>
<thead>
<tr>
<th></th>
<th>Part 1</th>
<th></th>
<th>Part 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of candidates</td>
<td>2942</td>
<td>Number of passing candidates</td>
<td>2128</td>
<td>Total number of marks available</td>
</tr>
<tr>
<td>% pass rate</td>
<td>72.33</td>
<td>Average % mark</td>
<td>76.12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total number of marks available</td>
<td>119(^1)</td>
<td>Average % mark</td>
</tr>
</tbody>
</table>

\(^1\) In a sitting, there are 40 questions in Part 1 and 120 questions in Part 2. At the post-assessment stage, the Board of Assessors may remove a question or accept more than one answer for a question, if there is evidence to support doing so. In this sitting, the Board of Assessors removed one question from Part 2. This adjusted the number of marks available to 119 in Part 2.

Table 1b: Paper pass marks

<table>
<thead>
<tr>
<th>Paper</th>
<th>Number of questions required to pass each part</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>26 (out of 40)</td>
</tr>
<tr>
<td>Part 2</td>
<td>85 (out of 119)</td>
</tr>
</tbody>
</table>

To pass the Registration Assessment, both parts must be passed.

The number of questions required to pass each part may vary from paper to paper and year to year depending on the difficulty of questions and papers.

Note that the number of questions required to pass is the standard and the pass rate is the percentage of candidates who met the standard.
Table 2: Performance by sitting attempt

<table>
<thead>
<tr>
<th>Sitting attempt</th>
<th>Number of candidates</th>
<th>Number of passing candidates</th>
<th>% pass rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>2677</td>
<td>2018</td>
<td>75.38</td>
</tr>
<tr>
<td>2nd</td>
<td>148</td>
<td>56</td>
<td>37.84</td>
</tr>
<tr>
<td>3rd</td>
<td>117</td>
<td>54</td>
<td>46.15</td>
</tr>
</tbody>
</table>

Note that data in Table 3 onwards are for 1st attempt sitters not the full cohort

Table 3: 1st attempt by education route

<table>
<thead>
<tr>
<th>Education route</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Part 1</td>
</tr>
<tr>
<td>MPharm degree</td>
<td>2589</td>
<td>75.55</td>
<td>77.40</td>
</tr>
<tr>
<td>OSPAP PGDip/MSc</td>
<td>88</td>
<td>70.45</td>
<td>72.76</td>
</tr>
</tbody>
</table>

Table 4: 1st attempt by sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Part 1</td>
</tr>
<tr>
<td>Male</td>
<td>839</td>
<td>71.16</td>
<td>76.85</td>
</tr>
<tr>
<td>Female</td>
<td>1687</td>
<td>77.06</td>
<td>77.42</td>
</tr>
</tbody>
</table>

2 ‘NULL’, ‘Prefer not to say’ and ‘Other’ have not been reported
Table 5: 1st attempt by age range

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 and over</td>
<td>84</td>
<td>47.62</td>
<td>62.89</td>
<td>74.24</td>
</tr>
<tr>
<td>26 - 35</td>
<td>215</td>
<td>58.60</td>
<td>70.27</td>
<td>76.39</td>
</tr>
<tr>
<td>25 and under</td>
<td>2378</td>
<td>77.88</td>
<td>78.39</td>
<td>79.71</td>
</tr>
</tbody>
</table>

Table 6: 1st attempt by country of pre-registration training

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2397</td>
<td>74.84</td>
<td>77.05</td>
<td>79.16</td>
</tr>
<tr>
<td>Scotland</td>
<td>180</td>
<td>81.67</td>
<td>79.58</td>
<td>80.32</td>
</tr>
<tr>
<td>Wales</td>
<td>100</td>
<td>77.00</td>
<td>77.80</td>
<td>80.08</td>
</tr>
</tbody>
</table>

Table 7: 1st attempt by pre-registration sector of training

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>748</td>
<td>93.18</td>
<td>84.34</td>
<td>83.78</td>
</tr>
<tr>
<td>Community</td>
<td>1904</td>
<td>68.17</td>
<td>74.44</td>
<td>77.45</td>
</tr>
</tbody>
</table>

3 A candidate’s sector refers to the placement of the longest duration. If placements of equal duration were undertaken, the sector of the most recent placement has been used.

4 Numbers of candidates from other sectors are too low to report (<20).
### Table 8: 1st attempt by ethnicity (≥ 20 candidates in a category)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any other ethnic group</td>
<td>101</td>
<td>64.36</td>
<td>70.54</td>
</tr>
<tr>
<td>Arab or Arab British</td>
<td>49</td>
<td>77.55</td>
<td>76.53</td>
</tr>
<tr>
<td>Asian or Asian British: Bangladeshi</td>
<td>107</td>
<td>67.29</td>
<td>75.56</td>
</tr>
<tr>
<td>Asian or Asian British: Indian</td>
<td>453</td>
<td>71.30</td>
<td>76.34</td>
</tr>
<tr>
<td>Asian or Asian British: Other</td>
<td>178</td>
<td>67.42</td>
<td>74.28</td>
</tr>
<tr>
<td>Asian or Asian British: Pakistani</td>
<td>350</td>
<td>65.71</td>
<td>72.92</td>
</tr>
<tr>
<td>Black or Black British: African</td>
<td>280</td>
<td>60.71</td>
<td>67.98</td>
</tr>
<tr>
<td>Chinese or Chinese British</td>
<td>245</td>
<td>82.45</td>
<td>83.21</td>
</tr>
<tr>
<td>Mixed: White and Asian</td>
<td>29</td>
<td>93.10</td>
<td>85.69</td>
</tr>
<tr>
<td>White: British</td>
<td>675</td>
<td>90.96</td>
<td>84.01</td>
</tr>
<tr>
<td>White: Irish</td>
<td>23</td>
<td>91.30</td>
<td>81.30</td>
</tr>
<tr>
<td>White: other</td>
<td>74</td>
<td>79.73</td>
<td>77.40</td>
</tr>
</tbody>
</table>

5 The following categories have not been reported because they contain <20 candidates: ‘Black or Black British: Other’, ‘Black or Black British: Caribbean’, ‘Mixed: White and Black African’ and ‘Mixed: Other’. In addition, ‘Not recorded’, ‘Not stated’ and ‘NULL’ have not been reported.
<table>
<thead>
<tr>
<th>School of Pharmacy</th>
<th>Number of candidates</th>
<th>% pass rate</th>
<th>Average % mark</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Part 1</td>
<td>Part 2</td>
<td></td>
</tr>
<tr>
<td>Aston University MPharm</td>
<td>91</td>
<td>82.42</td>
<td>81.18</td>
<td>79.98</td>
<td></td>
</tr>
<tr>
<td>University of Bath MPharm</td>
<td>101</td>
<td>91.09</td>
<td>84.11</td>
<td>84.41</td>
<td></td>
</tr>
<tr>
<td>University of Birmingham MPharm</td>
<td>55</td>
<td>81.82</td>
<td>78.82</td>
<td>79.28</td>
<td></td>
</tr>
<tr>
<td>University of Bradford (4-year continuous degree) MPharm</td>
<td>32</td>
<td>71.88</td>
<td>73.67</td>
<td>78.55</td>
<td></td>
</tr>
<tr>
<td>University of Bradford (5-year sandwich degree) MPharm</td>
<td>67</td>
<td>70.15</td>
<td>74.55</td>
<td>78.93</td>
<td></td>
</tr>
<tr>
<td>University of Brighton MPharm</td>
<td>93</td>
<td>51.61</td>
<td>68.60</td>
<td>74.46</td>
<td></td>
</tr>
<tr>
<td>University of Brighton OSPAP</td>
<td>22</td>
<td>59.09</td>
<td>70.00</td>
<td>75.25</td>
<td></td>
</tr>
<tr>
<td>Cardiff University MPharm</td>
<td>91</td>
<td>82.42</td>
<td>81.95</td>
<td>81.76</td>
<td></td>
</tr>
<tr>
<td>University of Central Lancashire MPharm</td>
<td>105</td>
<td>46.67</td>
<td>66.83</td>
<td>72.26</td>
<td></td>
</tr>
<tr>
<td>De Montfort University MPharm</td>
<td>119</td>
<td>70.59</td>
<td>75.06</td>
<td>78.44</td>
<td></td>
</tr>
<tr>
<td>University of Durham¹ MPharm</td>
<td>48</td>
<td>77.08</td>
<td>79.90</td>
<td>79.62</td>
<td></td>
</tr>
<tr>
<td>University of East Anglia MPharm</td>
<td>65</td>
<td>87.69</td>
<td>80.96</td>
<td>80.19</td>
<td></td>
</tr>
<tr>
<td>University of Hertfordshire MPharm</td>
<td>115</td>
<td>70.43</td>
<td>73.43</td>
<td>78.24</td>
<td></td>
</tr>
<tr>
<td>University of Hertfordshire OSPAP</td>
<td>23</td>
<td>52.15</td>
<td>70.87</td>
<td>78.08</td>
<td></td>
</tr>
<tr>
<td>University of Huddersfield MPharm</td>
<td>60</td>
<td>86.67</td>
<td>78.17</td>
<td>80.67</td>
<td></td>
</tr>
<tr>
<td>Keele University MPharm</td>
<td>59</td>
<td>71.19</td>
<td>73.81</td>
<td>77.31</td>
<td></td>
</tr>
<tr>
<td>King’s College London MPharm</td>
<td>110</td>
<td>79.09</td>
<td>79.20</td>
<td>79.35</td>
<td></td>
</tr>
<tr>
<td>Kingston University MPharm</td>
<td>120</td>
<td>55.83</td>
<td>70.62</td>
<td>74.97</td>
<td></td>
</tr>
<tr>
<td>University of Lincoln MPharm</td>
<td>34</td>
<td>67.65</td>
<td>73.97</td>
<td>78.03</td>
<td></td>
</tr>
<tr>
<td>Liverpool John Moores University MPharm</td>
<td>127</td>
<td>73.23</td>
<td>75.77</td>
<td>77.39</td>
<td></td>
</tr>
<tr>
<td>University of Manchester MPharm</td>
<td>134</td>
<td>85.07</td>
<td>80.84</td>
<td>81.47</td>
<td></td>
</tr>
<tr>
<td>Medway School of Pharmacy (universities of Greenwich and Kent) MPharm</td>
<td>84</td>
<td>70.24</td>
<td>75.24</td>
<td>79.89</td>
<td></td>
</tr>
<tr>
<td>University of Nottingham MPharm</td>
<td>187</td>
<td>89.30</td>
<td>84.12</td>
<td>82.45</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>Grade</td>
<td>Higher</td>
<td>2nd Year</td>
<td>Overall</td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>----------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>University of Portsmouth MPharm</td>
<td>82</td>
<td>64.63</td>
<td>72.29</td>
<td>77.33</td>
<td></td>
</tr>
<tr>
<td>University of Reading MPharm</td>
<td>82</td>
<td>67.07</td>
<td>76.16</td>
<td>77.81</td>
<td></td>
</tr>
<tr>
<td>The Robert Gordon University MPharm</td>
<td>78</td>
<td>71.79</td>
<td>74.58</td>
<td>77.10</td>
<td></td>
</tr>
<tr>
<td>University of Strathclyde MPharm</td>
<td>108</td>
<td>86.11</td>
<td>81.88</td>
<td>81.71</td>
<td></td>
</tr>
<tr>
<td>University of Sunderland MPharm</td>
<td>118</td>
<td>89.83</td>
<td>83.11</td>
<td>84.65</td>
<td></td>
</tr>
<tr>
<td>University of Sunderland OSPAP</td>
<td>21</td>
<td>90.48</td>
<td>75.71</td>
<td>82.47</td>
<td></td>
</tr>
<tr>
<td>University College London MPharm</td>
<td>125</td>
<td>92.80</td>
<td>84.44</td>
<td>82.35</td>
<td></td>
</tr>
<tr>
<td>University of Wolverhampton MPharm</td>
<td>61</td>
<td>47.54</td>
<td>64.88</td>
<td>73.23</td>
<td></td>
</tr>
</tbody>
</table>

6 An OSPAP is an Overseas Pharmacists’ Assessment Programme (postgraduate diploma or MSc).

7 Data have not been presented (1) for two OSPAPs (Aston University and Kingston University), (2) for The Queen’s University, Belfast and University of Ulster (most of whose graduates sit the PSNI’s Registration Examination in Northern Ireland) and (3) the two five-year integrated degrees at the University of East Anglia and University of Nottingham, because in all cases candidate numbers are <20.

8 Although the former school of pharmacy at the University of Durham has transferred to Newcastle University, the candidates sitting in June 2019 will be awarded a Durham MPharm degree so have been counted as ‘Durham’ students. The same will be the case in 2020.
Appendix 2

Report to the General Pharmaceutical Council’s Council on the June 2019 Registration Assessment

1. Introduction

1.1 The initial education and training of pharmacists in Great Britain is:

- a four-year MPharm degree accredited by the GPhC\(^1\); then
- 52 weeks of pharmacist pre-registration training; and
- the GPhC’s Registration Assessment.

or

- a five-year MPharm degree, with integrated pharmacist pre-registration training, accredited by
the GPhC; and
- the GPhC’s Registration Assessment.

1.2 During pre-registration training, trainees are signed-off on four occasions by a designated
pharmacist tutor – at 13, 26, 39 and 52 weeks. Trainees must have been signed off as ‘satisfactory’
at 39 weeks to be eligible to be entered for a sitting of the Registration Assessment.

1.3 The Registration Assessment is an examination with two papers: part 1 (morning) and part 2
(afternoon). It is based on the *Registration Assessment Framework*\(^2\), which covers:

- the outcomes to be assessed;
- the weighting of outcomes (high/medium/low);
- therapeutic areas which can be assessed;
- high risk drugs which can be assessed;
- proportion of paediatric questions; and
- calculations types.

---

\(^1\) Non-EEA pharmacists wanting to register in GB take a one-year university Overseas Pharmacists’ Assessment Programme (OSPAP) instead of an MPharm degree.

Note that not everything is tested in every sitting and the Framework is reviewed annually to ensure it remains current.

1.4 *Part 1*: The part 1 paper is two hours long (120 minutes) and comprises 40 calculations questions with free text responses. GPhC-approved models of calculator are permitted in Part 1.

1.5 *Part 2*: The part 2 paper is two and a half hours long (150 minutes) and comprises 120 questions: 90 are single best answer questions (SBAs) and 30 are extended matching questions (EMQs). Calculators are not permitted in Part 2.

1.6 Resource packs are provided for candidates, one for each part, and candidates are not permitted to bring any reference sources to the sitting. Examples of resources provided in packs include extracts from reference sources such as the national formularies (BNF & C-BNF), summaries of product characteristics (SmPCs, previously SPCs) as well as photographs, charts and tables.

1.7 Candidates with a specific need may ask for an adjustment to be made in the conduct of the assessment.

1.8 Candidates with specific needs may sit the assessment in a separate adjustments room and all centres have adjustment rooms.

2. **Reporting to Council**

2.1 There are two sittings of the Registration Assessment every year, in June and September, and the Board of Assessors reports to the GPhC’s Council after each one. This is the report for June 2019.

3. **June 2019 summary statistics**

<table>
<thead>
<tr>
<th>Candidate numbers</th>
<th>Number</th>
<th>% of total candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of candidates</td>
<td>2942</td>
<td>100%</td>
</tr>
<tr>
<td>Number of first sitting candidates</td>
<td>2677</td>
<td>91.0%</td>
</tr>
<tr>
<td>Number of second sitting candidates</td>
<td>148</td>
<td>5.0%</td>
</tr>
<tr>
<td>Number of third sitting candidates</td>
<td>117</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Candidate performance – pass rates</th>
<th>Number</th>
<th>% pass rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall pass</td>
<td>2128</td>
<td>72.3%</td>
</tr>
<tr>
<td>Overall fail</td>
<td>814</td>
<td>27.7%</td>
</tr>
<tr>
<td>First sitting candidates - pass</td>
<td>2018</td>
<td>75.4%</td>
</tr>
<tr>
<td>Second sitting candidates - pass</td>
<td>56</td>
<td>37.8%</td>
</tr>
<tr>
<td>Third sitting candidates - pass</td>
<td>54</td>
<td>46.2%</td>
</tr>
</tbody>
</table>
4. **Paper and question analysis**

*Question performance*

4.1 The questions performed well in both papers and only one from Part 2 was removed, based on an analysis of how the questions performed. This means that the pass mark for Part 2 was calculated using 119 questions not 120. In addition, two answers were accepted for one question.

4.2 There were errors in three questions, for which the Board apologises. The errors were identified during the sittings and announcements were made to candidates. In the case of two questions, the Board agreed that the error was minor and did not materially affect the questions and they were not removed; in the case of the third, the Board agreed that the error had affected the question and it was removed (the question referred to in 4.1).

*The balance of questions*

4.3 The balance of questions was consistent with the requirements of the *Registration Assessment Framework*:

<table>
<thead>
<tr>
<th>Weighting</th>
<th>June 2019</th>
<th>Permissible range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total % of the questions from high weighted outcomes</td>
<td>68.0%</td>
<td>60-70%</td>
</tr>
<tr>
<td>Total % of the questions from medium weighted outcomes</td>
<td>25.3%</td>
<td>25-35%</td>
</tr>
<tr>
<td>Total % of the questions from low weighted outcomes</td>
<td>6.7%</td>
<td>Up to 10%</td>
</tr>
</tbody>
</table>

*The pass rate*

4.4 The Board notes that the pass rate is lower than in previous years (the pass rate was 79% in 2018 and 78% in 2017). While the Board’s primary remit is to ensure that candidates who pass the registration assessment have demonstrated that they have met the standard required to be registered and does not take external factors in to account, the Board did note that the spread of pass rates by School of Pharmacy was particularly wide, with the highest pass rate being 92.80% and the lowest 47.54%. It is not the Board’s role to look in to these matters but it is concerned that variability in a number of different factors between the schools of pharmacy may be impacting on cohort performance in the Registration Assessment. This spread of pass rates by school of pharmacy appears noteworthy and the GPhC may wish to investigate this.

5. **Standard setting**

5.1 *Setting the standard*: the standard of each question is set by a panel of standard setters, who are all practising pharmacists with current experience of pre-registration trainees and early-years pharmacists. The standard of a paper is an aggregate of the standard for each question. Further information on creating papers and setting standards can be found at https://www.pharmacyregulation.org/education/pharmacist-pre-registration-training-scheme/key-dates-scheme/registration-assessment.
5.2 **Pass marks:** In order to pass the Registration Assessment, both Part 1 and Part 2 must be passed in the same sitting. The number of marks required to achieve a passing mark in each part in this sitting were:

- Part 1: 26 questions (/40 questions)
- Part 2: 85 questions (/119 questions)

5.3 **Pass rates:** The percentage of candidates achieving a passing mark for the papers were:

- Part 1: 80.9%
- Part 2: 80.3%

5.4 The pass rates for both parts are higher than the pass rate for the sitting as a whole, 72.33%, because a number of candidates achieved a passing mark in one paper but not both.

6. **Feedback to candidates and training providers**

6.1 Feedback to candidates is issued separately by the Board and posted on the GPhC’s website.

7. **Feedback to the BPSA**

7.1 As in previous years, the Board would like to thank the BPSA for its report, which was considered at the Board’s meeting on the 17th July 2019.

7.2 Some of the recommendations made by the BPSA are operational and will be considered by the GPhC; and some are out of scope for the Board.

7.3 Some of the points made by candidates about the coverage of the Registration Assessment are the same as those made previously on several occasions and for that reason the Board does not propose to repeat its answers. However, in relation to two points, the Board reiterates that all questions are linked to the Registration Assessment Framework without exception and that the balance of weighted questions is always within permissible ranges (see 4.3 above).

**Board of Assessors**
28 August 2019
Meeting paper

Council on Thursday, 12 September 2019

Public business

Regulation of Investigatory Powers: an update

Purpose
To update the Council on the development of our new governance framework relating to the regulation of investigatory powers.

Recommendations
The Council is asked to:

a. note our draft Regulation of Investigatory Powers policy and procedures (Appendix 1);

b. note the letter from the Investigatory Powers Commissioner, the Rt. Hon. Lord Justice Fulford dated 19 June 2019 and the associated inspection report (Appendix 2); and

c. note the overall progress update, including the upcoming programme of staff training.

1. Introduction

1.1 We have a range of enforcement options that we use to secure compliance with our standards for registered pharmacies, including recently revised statutory enforcement powers under the Pharmacy Order 2010 and the Medicines Act 1968. In March 2019, we published our new enforcement policy for registered pharmacies, which sets out the approach and principles we follow when using our enforcement options, supports consistent decision-making about when to use these options, and aligns to our wider approach to regulation.

1.2 Within our enforcement policy, we refer to other legislation relevant to our investigatory and enforcement work, including the Regulation of Investigatory Powers Act 2000 (“RIPA”). On publication, we indicated that further work was planned to develop a new governance framework in this area following recent legislative change enabling us to use covert investigatory powers for the first time. This paper provides an update on that work and reports on the outcome of our recent inspection by the Investigatory Powers Commissioner, who has responsibility for reviewing the use of investigatory powers by public authorities and adherence to Home Office Codes of Practice.

2. Legal background

2.1 By way of background, RIPA provides a statutory framework regulating the carrying out of covert surveillance by “relevant public authorities” consistent with the Human Rights Act 1998. Its aim is to
provide the right balance between protecting privacy and the proper use of data and surveillance to help carry out evidence gathering, in accordance with relevant human rights legislation. “Relevant public authorities” for these purposes are specified in the legislation and an authorisation under RIPA, providing the relevant statutory tests are met, provides these public authorities with the lawful basis to carry out covert (directed) surveillance activity in their investigations, where appropriate.

2.2 Prior to 2010, the Royal Pharmaceutical Society of Great Britain (RPSGB) was listed under Schedule 1 of RIPA, as a relevant public authority for the purposes of Section 28 (directed surveillance). The Pharmacy Order 2010 made a number of consequential amendments to other legislation to reflect the transfer of regulatory functions from the RPSGB to the GPhC, including the appropriate update to Schedule 1 of RIPA. However, no equivalent amendment was made to Schedule 1 of the Regulation of Investigatory Powers (Directed Surveillance and Covert Human Intelligence Sources) Order 2010. As a result, the GPhC has not been able to use directed surveillance powers without the necessary changes to correct this legislative drafting anomaly.

2.3 The legislation was finally updated in July 2018 with the introduction of the Investigatory Powers (Codes of Practice and Miscellaneous Amendments) Order 2018. This Order brought about the necessary housekeeping changes to ensure that the right public authorities are able to continue to use RIPA powers, that they can be used effectively and that they are correctly authorised. It included a number of changes to offices, ranks and positions, and organisational structures since 2010 when the list was last updated. This included removing the out of date reference to the RPSGB and setting new authorisation levels for directed surveillance within the GPhC. The Order also brought into force three revised Home Office Codes of Practice relating to functions carried out under RIPA.

3. Developing our governance framework

3.1 Following on from this change, we have been developing the policies and procedures necessary to represent a compliant RIPA structure and framework, which will include mandatory staff training for staff and Authorising Officers engaged in RIPA activities. It is important to emphasise that, at this stage, we have not yet authorised, or sought to authorise, any directed surveillance under RIPA.

3.2 The Council is asked to note our draft policy and procedures attached at Appendix 1. These documents:

- set out in more detail the statutory framework that regulates our use of covert surveillance
- outline the statutory criteria we take into account when deciding whether to use covert surveillance
- explain the authorisation procedures that we follow
- provide examples of the situations where we will consider using covert surveillance (please note that the examples included in the draft policy are for guidance and illustrative purposes only, as it is not possible to replicate the same level of detail as real cases)

3.3 It is also important to note that we will only carry out directed surveillance in very limited cases where such action is justified and all relevant criteria are met. Directed surveillance will always be a last resort in an investigation and will only be undertaken where this is properly authorised, lawful, proportionate and necessary, and where there are no other reasonable and less intrusive means of obtaining the
information required. In making such decisions, we follow the statutory legal framework as well as the detailed guidance in the relevant Home Office Codes of Practice.

3.4 RIPA does not prejudice or dis-apply any existing powers available to the GPhC to obtain information by other methods not involving conduct authorised under RIPA. For example, it does not affect our powers under the Pharmacy Order 2010 or the Medicines Act 1968.

3.5 Additionally, our policy and procedures clearly set out the limitations of our investigatory techniques and surveillance activities under RIPA. For example, we do not have the authority to authorise intrusive surveillance (for example, relating to residential premises or private vehicles) or to use covert human intelligence sources (for example using an informant or someone acting undercover). And, we do not, for example, have powers to obtain communications data under the more recent Investigatory Powers Act 2016 (“IPA”) and associated Regulations.

3.6 In terms of territorial extent, where the activity is likely to take place in Scotland, authorisations should be granted under the Regulation of Investigatory Powers (Scotland) Act 2000 (“RIPSA”) unless the authorisation is being obtained by certain public authorities under section 46 of RIPA and the Regulation of Investigatory Powers (Authorisations Extending to Scotland) Order 2007). The GPhC is covered by the 2007 Order (later amended by the Pharmacy Order 2010), which enables us to carry out regulated activity in Scotland without engaging RIP(S)A.

4. **Inspection by the Investigatory Powers Commissioner**

4.1 The Investigatory Powers Commissioner’s Office (IPCO) provides independent oversight of the use of investigatory powers by intelligence agencies, police forces and other public authorities. The Investigatory Powers Commissioner is supported by a team of Judicial Commissioners and inspectors, and ensures compliance with the law by inspecting public authorities and investigating any issues which they believe warrant further independent scrutiny. As a relevant public authority under RIPA, the GPhC is subject to this inspection regime.

4.2 The IPCO carried out its inspection of the GPhC on 10 May 2019. This was designed to assess our level of compliance with RIPA in respect of our use and management of directed surveillance. In light of the complex background and recent legislative changes, the inspection focused on the work done thus far by the GPhC in achieving a state of readiness for using any of the investigatory powers granted to it. The inspection methodology comprised of interviews with key members of staff identified as being responsible for discharging functions attached to the use of RIPA investigatory powers. This included the Chief Executive & Registrar, the Chief of Staff, the Director of Insight, Intelligence and Inspection, and the Head of Inspection.

4.3 The outcome of the inspection is attached at Appendix 2. This includes the letter from the Investigatory Powers Commissioner, the Rt. Hon. Lord Justice Fulford dated 19 June 2019 and the associated inspection report. Overall, the inspection indicated that the GPhC has been preparing itself well in advance of considering the use of covert investigative methods and is on track to establishing a robust governance regime and compliant with the legislation and codes of practice. No formal recommendations were made as a result of the inspection. The report highlighted a number of areas where we have demonstrated good practice, and we have made a small number of minor updates to the draft policy and procedures to reflect advice from the Commissioner.
4.4 The inspection also provided us with the opportunity to discuss the challenges in regulating the online marketplace. As highlighted in the report, the advent of a significantly greater online marketplace and cyber enabled criminality has the potential to make traditional forms of inspection and investigation less effective. As supported by the Commissioner, we are currently carrying out further work on the use of online covert activity and seeking specialist advice on these aspects.

4.5 The GPhC will also be subject to a further inspection by the IPCO within the next 18 months to ensure that this momentum is maintained, and to provide support for the use of these powers in relation to covert online activity.

5. Equality and diversity

5.1 RIPA provides a clear statutory framework under which covert investigatory techniques can be authorised and carried out compatibly with human rights legislation. We will also ensure that our application and authorisation processes take account of wider equality and diversity considerations, including appropriate monitoring to guard against any discrimination in the very limited number of cases where we are likely to use these powers.

6. Communications

6.1 In line with the approach taken with our wider enforcement policy, we plan to publish our RIPA policy and procedures in due course. We have sought specific advice from the IPCO about the extent to which public authorities are expected to publish this type of documentation alongside the need to achieve the right balance between openness and transparency on the one hand and any prejudicial impact on investigations and operations on the other. The IPCO advised that public authorities should publish as much as possible provided this does not impact on operational security or the integrity of investigative tactics and were in support of publication.

6.2 Our policy and procedures will also be shared internally with relevant staff and teams. Additionally, we are embarking on a detailed programme of training to ensure that staff in relevant RIPA roles are adequately trained and are current in respect of their knowledge.

6.3 The first training session for all GPhC inspectors will be held on Friday, 13 September 2019. Further sessions have also been scheduled for relevant teams in the Fitness to Practise Directorate. And, further training sessions are being held for Directors who will occupy the roles of ‘Authorising Officers’. Once the initial training sessions have been completed, we will identify any requirements for more specialist or bespoke training going forward.

7. Resource implications

7.1 There are no additional resource implications associated with this work as it currently stands. This will of course be monitored in line with any future regulatory action we may need to take in response specific investigations or operations, or in response to any future recommendations from the IPCO. The need for specialist advice relating to online covert activity has been provided for in existing budgets.

8. Risk implications
8.1 RIPA provides a clear statutory framework for the operation of certain intrusive investigatory techniques and to ensure that this type of activity can be authorised and conducted compatibly with the Human Rights Act. It is essential that our policy and procedures reflect the relevant statutory framework and Codes of Practice, and that we assess and understand whether, and in what circumstances, it is appropriate to use covert surveillance techniques.

8.2 All GPhC staff involved in requesting, authorising and conducting covert surveillance techniques are responsible for following the law, the relevant Home Office Codes of Practice and the guidance set out in our policy and procedures. This will be reinforced through appropriate training and ongoing monitoring, as well as through strict application and authorisation processes.

9. Monitoring and review

9.1 The IPCO provides robust oversight and scrutiny of our work in this area, including through the inspection process. Additionally, our governance framework includes a Senior Responsible Officer (SRO), who is responsible for a number of important aspects including the overall integrity of the process in place to authorise directed surveillance; compliance with the relevant legislation and Home Office Codes of Practice; specifying appropriate officers able to grant RIPA authorisations (Authorising Officers) in line with the legislation; and overseeing the process for reporting any errors to the IPCO and addressing any recommendations.

9.2 Our governance framework also includes a RIPA Monitoring Officer (RMO), who will maintain a central register of all authorisations, grants, refusals, reviews, renewals and cancellations in line with the Home Office Codes of Practice. We have worked closely with our Information Governance team when designing our governance framework, to ensure that we have appropriate procedures in place relating to the handling and retention of information obtained under an authorisation and the associated considerations relating to data protection and privacy.

9.3 Finally, as highlighted at paragraph 5.1 above, our wider monitoring will also include equality and diversity aspects, to guard against any discrimination in the limited number of cases where we are likely to use these powers.

Recommendations

The Council is asked to:

a. note our draft Regulation of Investigatory Powers policy and procedures (Appendix 1);

b. note the letter from the Investigatory Powers Commissioner, the Rt. Hon. Lord Justice Fulford dated 19 June 2019 and the associated inspection report (Appendix 2); and

c. note the overall progress update, including the upcoming programme of staff training.

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28 August 2019
1. Introduction

What this policy is for

1.1 We have an important role in providing assurances to people that the pharmacy services they and their families use will be safe and effective. We also want to drive continuous improvement in the quality of care that people receive when using pharmacy services. We act to protect the public and to uphold public confidence in pharmacy if there are concerns about a pharmacy professional or pharmacy on our register.

1.2 We have a range of enforcement options that we use to achieve these objectives, including statutory enforcement powers set out in the Pharmacy Order 2010 and the Medicines Act 1968. Our approach to enforcement is set out in our registered pharmacies enforcement policy.

1.3 On occasion, and to ensure regulatory compliance, it may be necessary for us to undertake the use of covert investigatory techniques and surveillance activities in the context of our investigatory and enforcement work. An authorisation under the Regulation of Investigatory Powers Act 2000 (‘RIPA’), providing the relevant statutory tests are met, provides us with the lawful basis to carry out covert (directed) surveillance activity. These powers also extend to regulated activities carried out in Scotland.

1.4 The specific purposes for which we may obtain a directed surveillance authorisation are laid out in legislation. This allows us to use covert investigatory techniques and surveillance activities in limited situations:

- when this is necessary for the purpose of preventing or detecting crime or preventing disorder
- in the interests of public safety
- for the purpose of protecting public health (for example, investigations into illicit sale of medicines)

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1 The Regulation of Investigation Powers Act 2000, Schedule 1, Part II (Relevant Public Authorities)
2 The Regulation of Investigatory Powers (Authorisations Extending to Scotland) Order 2007 (as amended by the Pharmacy Order 2010)
3 The Regulation of Investigatory Powers (Directed Surveillance and Covert Human Intelligence Sources) Order 2010 (as amended by the Investigatory Powers (Codes of Practice and Miscellaneous Amendments) Order 2018)
1.5 RIPA gives the GPhC, as a public authority, a clear legal framework to follow when we are conducting surveillance activities and regulates the way in which our investigations are carried out. Its aim is to provide the right balance between protecting privacy and the proper use of data and surveillance to help carry out evidence gathering, in accordance with relevant human rights legislation. This policy:

- sets out the statutory framework that regulates our use of covert surveillance
- outlines the statutory criteria we take into account when deciding whether to use covert surveillance
- explains the authorisation procedures that we follow
- provides examples of the situations where we will consider using covert surveillance

1.6 It is important to note that we only carry out directed surveillance in very limited cases where such action is justified and all relevant criteria are met. Directed surveillance will always be a last resort in an investigation and will only be undertaken where this is properly authorised, lawful, proportionate and necessary, and where there are no other reasonable and less intrusive means of obtaining the information required.

2. The legal framework and Codes of Practice

2.1 It is the responsibility of all public bodies, including the GPhC, to comply fully with the requirements of the Human Rights Act (HRA) 1998. RIPA was enacted in order to give a clear statutory framework for the operation of certain intrusive investigatory techniques and to ensure that this type of activity can be authorised and conducted compatibly with the HRA. Essentially RIPA requires the following human rights principles to be complied with for investigatory work:

- The proposed action must be lawful
- The proposed action must be proportionate
- The proposed action must be necessary
- The proposed action must be non-discriminatory

2.2 The procedures and guidance set out in this policy are based on the provisions of RIPA, and related legislation and Home Office Codes of Practice. The Home Office Codes are designed to help public authorities assess and understand whether, and in what circumstances, it is appropriate to use covert surveillance techniques.

2.3 The Codes also provide guidance on when an application should be made, the procedures that need to be followed in each case, and the handling of information obtained by surveillance activities. The code of practice which has the most significant impact on the activities of the GPhC is the Code of Practice on Covert Surveillance and Property Interference.

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4 Please note that the examples included in this policy are for guidance and illustrative purposes only, as it is not possible to replicate the same level of detail as real cases.
2.4 All GPhC staff involved in requesting, authorising and conducting covert surveillance techniques are responsible for following the law, the relevant Home Office Codes of Practice and the guidance set out in this policy.

3. What RIPA does and does not do

3.1 RIPA requires prior authorisation internally (by a Director) of all directed surveillance. However, RIPA does not enable the GPhC to carry out intrusive surveillance or to use a Covert Human Intelligence Source (CHIS). These terms are explained in more detail below.

3.2 Additionally, RIPA does not prejudice or dis-apply any existing powers available to the GPhC to obtain information by other methods not involving conduct authorised under RIPA. For example, it does not affect our powers under the Pharmacy Order 2010 or the Medicines Act 1968.

4. Types of surveillance

4.1 RIPA authorisation is not required for all surveillance. It only applies to covert surveillance that is likely to result in obtaining private information about a person.

4.2 In short, RIPA regulates two types of covert surveillance: directed / intrusive surveillance and the use of Covert Human Intelligence Sources (CHIS).

4.3 The GPhC does not carry out intrusive surveillance or authorise the use of CHIS. However, there are different types of surveillance that may be used as part of our investigations:

- General surveillance (not directed at an individual)
- Covert surveillance (directed)

4.4 There is more information about these different types of surveillance below.

General observation duties

4.5 The general observation duties of public authorities do not require authorisation under the 2000 Act, whether covert or overt. Such general observation duties frequently form part of the legislative functions of public authorities, as opposed to the pre-planned surveillance of a specific person or group of people.

4.6 General observation duties may include monitoring of publicly accessible areas of the internet in circumstances where it is not part of a specific investigation or operation.

4.7 For specific investigations, most of the surveillance carried out by the GPhC will be done overtly – there will be nothing secretive or hidden about it.

4.8 Similarly, surveillance is overt when we have explained that this will happen (for example, where we inform pharmacy owners that we will visit pharmacy premises without notice or identifying themselves to the pharmacy owner to check that the enforcement action is being complied with).
Covert surveillance

4.9 Part II of RIPA 2000 provides for the authorisation of covert surveillance by public authorities listed at Schedule 1 of the 2000 Act where that surveillance is likely to result in obtaining private information about a person.

4.10 Surveillance, for the purpose of RIPA, includes monitoring, observing, listening to persons, their movements, their conversations or other activities and communications. This may be conducted with or without the assistance of a surveillance device, and includes the recording of any information obtained.

4.11 Surveillance is defined as covert ‘If, and only if, it is carried out in a manner that is calculated to ensure that the persons who are subject to surveillance are unaware that it is or may be taking place’.

4.12 Private information includes any information relating to a person’s private or family life. This is explained in more detail below.

Directed surveillance

4.13 Surveillance is ‘directed surveillance’ if the following are all true:

- It is covert, but not intrusive surveillance (see definition below— the GPhC must not carry out any intrusive surveillance)
- It is conducted for the purpose of a specific investigation or operation
- It is likely to result in the obtaining of private information about a person (whether or not that person is specifically identified for purposes of an investigation or operation)
- It is conducted otherwise than by way of an immediate response to events or circumstances such that it is not reasonably practicable to seek authorisation under RIPA.

What is ‘private information’?

4.14 The planned covert surveillance of a specific person, where not intrusive, constitutes directed surveillance if such surveillance is likely to result in obtaining private information about that individual, or any other person.

4.15 Private information includes any information relating to a person’s private or family life. As a result, private information is capable of including any aspect of a person’s private or personal relationship with others, such as family and professional or business relationships. Information

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5 Section 48(2) of the Regulation of Investigatory Powers Act 2000
6 Section 26(9)(a) of the Regulation of Investigatory Powers Act 2000
7 Section 26(10) of the Regulation of Investigatory Powers Act 2000
which is non-private may include publicly available information\textsuperscript{8}. Private information may include personal data such as names, telephone numbers and address details.

4.16 The key issue in directed surveillance is the targeting of an individual with the intention of gaining private information. This includes any information relating to private and family life, home and correspondence. The fact that covert surveillance occurs in a public place or on business premises does not mean that it cannot result in the obtaining of private information about a person. Prolonged surveillance targeted on a single person will undoubtedly result in the obtaining of private information about that person and others that they come into contact, or associate with.

4.17 Whilst a person may have a reduced expectation of privacy when in a public place, covert surveillance of that person’s activities in public may still result in the obtaining of private information. This is likely to be the case where that person has a reasonable expectation of privacy even though acting in public and where a record is being made by a public authority of that person’s activities for future consideration or analysis.

**Covert - Intrusive surveillance**

4.18 Surveillance is ‘intrusive surveillance’ if it:

- Is covert
- Is carried out in relation to anything taking place on any residential premises, or in any private vehicle, and
- Involves the presence of an individual on the premises or in the vehicle, or
- Is carried out by means of a surveillance device

4.19 The definition of surveillance as intrusive relates to the location of the surveillance and not any other considerations of the nature of the information that is expected to be obtained, as it is assumed that intrusive surveillance will always be likely to result in obtaining private information about an individual. It is not therefore necessary to consider whether or not intrusive surveillance is likely to result in obtaining private information.

4.20 Please note that the GPhC does not have authority to authorise intrusive surveillance in accordance with RIPA.

**Covert Human Intelligence Sources (CHIS)**

4.21 A CHIS is someone who establishes or maintains a personal or other relationship for the purpose of covertly using the relationship to obtain information or provide access to any information to another person, or covertly discloses information obtained by means of that relationship.

\textsuperscript{8} Chapter 3 of the Home Office ‘Covert Surveillance and Property Interference, Revised Code of Practice’, August 2018
relationship is established or maintained for a covert purpose if and only if it is conducted in a manner that is calculated to ensure that one of the parties to the relationship is unaware of the purpose. An example would be using an informant or someone acting undercover.

4.22 Please note that the GPhC does not have the authority to authorise the use of a CHIS.

Examples of surveillance activities

4.23 There are examples of surveillance activities set out at Annex A. This includes examples of what the GPhC can and cannot do, along with further information relating to online covert activity.

5. General authorisation considerations

Proportionality and necessity

5.1 The law requires that the person granting an authorisation for directed surveillance must believe that the activities to be authorised are necessary on one or more statutory grounds (there is more information about these statutory grounds in section 6 below).

5.2 If the activities are deemed necessary on one or more of these statutory grounds, the person granting the authorisation must also believe that they are proportionate to what is sought to be achieved by carrying them out. This involves balancing the seriousness of the intrusion into the privacy of the subject of the operation (or any other person who may be affected) against the need for the activity in investigative and operational terms.

5.3 An authorisation will not be proportionate if it is excessive in the overall circumstances of the case or investigation, or where the information which is sought could reasonably be obtained by other less intrusive means.

5.4 We consider the following elements of proportionality in all cases where surveillance is considered:

- balancing the size and scope of the proposed activity against the gravity and extent of the perceived crime or harm;
- explaining how and why the methods to be adopted will cause the least possible intrusion on the subject and others;
- considering whether the activity is an appropriate use of the legislation and a reasonable way, having considered all reasonable alternatives, of obtaining the information sought;
- evidencing, as far as reasonably practicable, what other methods had been considered and why they were not implemented, or have been implemented unsuccessfully.

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9 These statutory grounds are laid out in sections 28(3) of the 2000 Act for directed surveillance
5.5 Any surveillance involved in a case, even if it does not form part of an eventual prosecution case, may be deemed unlawful if not properly authorised and could lead to a challenge under Article 8 of the European Convention on Human Rights (ECHR).

5.6 All GPhC staff involved in undertaking surveillance activities are fully aware of the extent and limits of the authorisation in question.

**Collateral intrusion**

5.7 When considering the use of surveillance techniques, we take account of the risk of intrusion into the privacy of persons other than the specified subject of the surveillance (this is known as ‘collateral intrusion’).

5.8 We take appropriate measures, wherever practicable, to avoid or minimise collateral intrusion and the matter may be an aspect of determining proportionality.

5.9 Where such collateral intrusion is unavoidable, the activities may still be authorised, provided this intrusion is considered proportionate to what is sought to be achieved. The same proportionality tests apply to anticipated collateral intrusion as to intrusion into the privacy of the intended subject of the surveillance.

5.10 All authorisation applications should include an assessment of the risk of collateral intrusion, and the details of measures to limit this, to enable the Authorising Officer to fully consider the proportionality of the proposed actions.

**6. Authorisation procedures**

**Statutory criteria**

6.1 Directed surveillance can only be lawfully carried out if properly authorised, and in strict accordance with the terms of the authorisation. An authorisation for directed surveillance may be granted by an Authorising Officer where they believe that the authorisation is necessary in the circumstances of the particular case on the grounds that it is\(^{10}\):

- for the purpose of preventing or detecting crime or of preventing disorder;
- in the interests of public safety;
- for the purpose of protecting public health (this includes investigations into illicit sale of medicines).

6.2 The Authorising Officer must also believe that the surveillance is proportionate to what it seeks to achieve (see above).

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\(^{10}\) Section 28(3) of the 2000 Act
General best practice

6.3 We take account of the following best practice guidelines for all our work conducted under RIPA:

- applications should avoid any repetition of information;
- information contained in applications should be limited to that required by the relevant legislation and the requirements of the relevant Home Office Code of Practice;
- the case for the authorisation should be presented in the application in a fair and balanced way. In particular, all reasonable efforts should be made to take account of information which supports or weakens the case for the authorisation;
- an application should not require the sanction of any person in a public authority other than the Authorising Officer;
- where it is foreseen that other agencies will be involved in carrying out the surveillance, these agencies should be detailed in the application;
- authorisations should not generally be sought for activities already authorised following an application by the same or a different agency

Applying for an authorisation

6.1 An application for authorisation must be made in writing and this should include full details of the proposed surveillance and the duration. The application must include the following information:

a. the reasons why the authorisation is necessary in the particular case and on which statutory grounds (e.g. in the interests of public safety listed in Section 28(3) of the 2000 Act)
b. the nature of the surveillance
c. the identities, where known, of those to be subject to the surveillance
d. a summary of the case or investigation
e. the action/surveillance to be authorised
f. the information which is sought from the action/surveillance
g. the potential for any collateral intrusion and why this is justified, including a plan to minimise this
h. details of any confidential or privileged information that is likely to be obtained as a result of the surveillance
i. why the action/surveillance is proportionate to what it seeks to achieve (there must be a clear indication of what alternative methods were considered for obtaining the information required and why these were rejected, and it may be useful to state that this is the only way the evidence can be gathered)
j. the level of authorisation required for the action/surveillance
6.2 Applications for authorisation must be presented in a fair and balanced way, with all reasonable efforts being made to take account of information that weakens the case for an authorisation.

Key roles and responsibilities

Senior Responsible Officer (SRO)

6.4 [...] is the Senior Responsible Officer (SRO) for RIPA within the GPhC. The SRO is responsible for:

• the integrity of the process in place to authorise directed surveillance
• compliance with the relevant legislation and Home Office Codes of Practice
• specifying appropriate officers able to grant RIPA authorisations (Authorising Officers)
• verifying the competency of Authorising Officers through training
• engaging with the Investigatory Powers Commissioner’s Office (IPCO) and inspectors when they conduct their inspections
• overseeing the process for reporting any errors to the IPCO and addressing any recommendations

Authorising Officers (AOs)

6.5 The use of directed surveillance for a particular investigation must be subject to prior authorisation by an officer of a rank or position at least as senior as is specified in Regulations made under RIPA. For the GPhC, ‘Authorising Officers’ are Directors, or the Chief Executive & Registrar for enhanced authorisations. See paragraphs 6.12 to 6.15 below for more information about enhanced authorisations.

6.6 Authorising Officers may not sub-delegate their powers in relation to RIPA to other GPhC staff. Authorising Officers must also ensure that staff who report to them follow this document and do not undertake or carry out any form of surveillance without first obtaining the relevant authorisations.

6.7 Generally, authorisations are not made by an Authorising Officer directly involved in the investigation or operation, so that there is independent review of whether the surveillance is necessary and proportionate. However, this may sometimes be unavoidable, for example, where it is necessary to act quickly.

6.8 If there is any doubt about the appropriateness of a proposed course of investigatory action, Authorising Officers are required to Senior Authorising Officer (SRO) BEFORE any directed surveillance is authorised, renewed, cancelled or rejected.

6.9 Authorising Officers should be aware of the following simplified way of remembering RIPA by the acronym ‘PLAN’ - all covert surveillance must be proportional, lawful, authorised and necessary:

• Proportionate

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11 The Investigatory Powers (Codes of Practice and Miscellaneous Amendments) Order 2018
• **Lawful**
• **Authorised (by a proper person)**
• **Necessary (having considered alternatives)**

6.10 RIPA and the associated Codes of Practice do not require a risk assessment to be completed in respect of directed surveillance. However, it is GPhC policy that Authorising Officers must pay particular attention to health and safety issues that may be raised by any proposed surveillance activity. Under no circumstances, should an Authorising Officer approve any RIPA form unless, and until they are satisfied the health and safety of GPhC employees/agents are suitably addressed and/or risks minimised, so far as is possible, and proportionate to/with the surveillance being proposed. If an Authorising Officer is in any doubt, they should obtain prior guidance on the same from the SRO.

6.11 The SRO is responsible for ensuring that Authorising Officers are suitably trained on RIPA and the application of this policy.

**Enhanced authorisations (for confidential information)**

6.12 A higher level of authorisation is required in respect of directed surveillance authorisations when knowledge of confidential information is likely to be acquired. The authorisation levels are set at a more senior level than that required for other surveillance activity, reflecting the sensitive nature of such information. For the GPhC authorisation should be obtained from the Chief Executive & Registrar.12

6.13 Confidential information consists of communications subject to legal privilege and confidential personal information. For example, confidential personal information includes information held in confidence concerning an individual who can be identified from it, and the material in question relates to their physical or mental health.

6.14 Such information can include both oral and written communications. Such information as described above is held in confidence if it is held subject to an express or implied undertaking to hold it in confidence or it is subject to a restriction on disclosure or any legal obligation of confidentiality. For example, confidential personal information might include consultations between a health professional and a patient, or information from a patient’s medical records.

6.15 There is further information about the meaning of confidential information in the relevant Home Office Code of Practice.

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12 Enhanced authorisation levels for the GPhC are specified in Home Office Code of Practice on Covert Surveillance and Property Interference, Annex A, page 94
Duration of authorisations (including renewals and cancellations)

6.16 A written authorisation granted by an authorising officer will cease to have effect (unless renewed or cancelled) at the end of a period of three months beginning with the day when the authorisation granted had taken effect.\(^{13}\)

6.17 Even in instances where it is anticipated that an authorisation will only be required for a period of time less than three months, authorisation should still be granted for the statutory three-month period, subject to review at an interval reflecting expected duration, and the authorisation cancelled when it is no longer necessary.

Renewals

6.18 Authorisations for directed surveillance may be renewed. When considering whether to renew such an authorisation, the Authorising Officer should give consideration to the same criteria as they would were they considering a new application.

6.19 If, at any time before an authorisation for directed surveillance granted by an Authorising Officer ceases to have effect, and the Authorising Officer considers it necessary for the authorisation to continue for the purpose for which it was given, they may renew it in writing for a further period of three months. The renewal will take effect at the time at which the authorisation would have ceased to have effect but for the renewal.

6.20 Authorisations may be renewed more than once, if necessary and proportionate, and provided they continue to meet the criteria for authorisation.

Cancellations

6.21 Authorising Officers must cancel the authorisation at any time if they consider that the directed surveillance no longer meets the criteria upon which it was authorised.

6.22 Authorisations must also be kept under review and those acting under an authorisation must notify the authorising officer if they consider that the authorisation is no longer necessary or proportionate, and so should therefore be cancelled.

6.23 As soon as the decision is taken that directed surveillance should be discontinued, the instruction must be given to those involved to stop all surveillance of the subject(s) as soon as reasonably practicable.

6.24 Information about renewals and cancellations will be recorded and retained centrally in line with Home Office guidance (see below for more information).

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\(^{13}\) Section 43(3)(c) of the 2000 Act
7. Working with other agencies

7.1 As part of our enforcement activities, we work collaboratively with other regulators and agencies to ensure that the most appropriate organisation manages the concerns.

7.2 We consider whether any other public authorities or agency is undertaking similar activities which could impact on the deployment of surveillance activities.

7.3 Where possible, we seek to avoid duplication of authorisations as part of a single investigation or operation. For example, where two agencies are conducting directed surveillance as part of a joint operation, only one authorisation is required.

7.4 In some circumstances, it may be appropriate or necessary for public authorities to work with third parties to assist with an investigation. Authorisation may therefore be required for the activities undertaken on the public authority’s behalf.

8. Recording and retaining information

8.1 We retain information about authorisations (including cancellations and renewals) for at least three years from the end of each authorisation. This information is regularly updated whenever an authorisation is granted, renewed or cancelled and is available to the Investigatory Powers Commissioner and inspectors who support the work of the Commissioner upon request.

9. Oversight and inspection

9.1 The Investigatory Powers Commissioner (the Commissioner) has responsibility for reviewing the use of investigatory powers by public authorities and adherence to Home Office Codes of Practice. The Commissioner is supported by inspectors and others, and ensures compliance with the law by inspecting public authorities and investigating any issues which they believe warrant further independent scrutiny. The GPhC is subject to inspection by the Commissioner.

9.2 Any GPhC staff member who has concerns about the way that investigatory powers are being used may report their concerns to the Commissioner. The GPhC must also report to the Commissioner any relevant error of which they are aware. This may be in addition to the person raising concerns through the internal mechanisms for raising concerns within the public authority.

9.3 Further information about the Investigatory Powers Commissioner, their office and their work may be found at: www.ipco.org.uk

10. Complaints
10.1 The Investigatory Powers Tribunal (IPT) has jurisdiction to investigate and determine complaints against public authority use of investigatory powers. The IPT is entirely independent from Government and all public authorities who use investigatory powers.

10.2 Any complaints about the GPhC’s use of powers should be directed to the IPT. Following receipt of a complaint or claim from a person, the IPT can undertake its own enquiries and investigations.

10.3 Should you wish to find out more information about the IPT or make a complaint, then full details of how to do so are available on the IPT website: www.ipt-uk.com.

Annex A: Examples of surveillance activities

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<tr>
<th>Type of surveillance</th>
<th>Examples</th>
<th>Authorisation</th>
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<td>Not available to the GPhC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covert Human Intelligence Sources (CHIS)</td>
<td>Someone who establishes or maintains a personal or other relationship for the covert purpose of helping to obtain information. For example, using an informant or someone acting undercover to obtain information and evidence where that individual interacts with the subject of surveillance.</td>
<td>Not applicable - the GPhC cannot and will not authorise this sort of activity (CHIS authorisation required)</td>
</tr>
<tr>
<td>Covert – intrusive</td>
<td>Planting a listening device in a person’s home or in their vehicle.</td>
<td>Not applicable - the GPhC cannot and will not authorise this sort of activity</td>
</tr>
<tr>
<td>Covert Human Intelligence Sources (CHIS) – for online activity</td>
<td>A GPhC inspector engaging with others online without disclosing their identity. [However, it would be possible to do certain types of online test purchases without straying into CHIS. For example, a single online test purchase where there is no private correspondence with the seller and no covert relationship formed, a CHIS authorisation need not be sought]</td>
<td>Not applicable - the GPhC cannot and will not authorise this sort of activity (CHIS authorisation required)</td>
</tr>
<tr>
<td>Available to the GPhC subject to appropriate RIPA authorisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covert – directed</td>
<td>A GPhC inspector monitoring an individual over a period of time to establish whether they are selling medicines illegally from a registered pharmacy premises.</td>
<td>Yes – RIPA authorisation required</td>
</tr>
<tr>
<td>Covert – directed</td>
<td>A GPhC inspector carrying out a series of test purchases where it is suspected that a person is selling medicines illegally from a registered pharmacy premises, which includes surveillance over and above the transaction itself, and which is likely to result in obtaining private information about an individual. This may include the use of a hidden camera or other recording device. However, a simple test purchase conducted by a GPhC inspector, which does not involve any surveillance over and above the transaction itself, and which is not likely to obtaining private information about an individual will not generally require RIPA authorisation. In this case, the inspector will be acting no differently to a member of the public. (Test purchases can also amount to a CHIS. Whether or not a ‘relationship’ exists depends on all the circumstances including the length of time of the contact between the seller and the buyer, and the nature of any covert activity. The GPhC is not permitted to carry out test purchases that amount to a CHIS).</td>
<td>Yes – RIPA authorisation required</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Online activity</td>
<td>Monitoring and extracting information from a social media profile, for retention in a record because it is relevant to an investigation or operation.</td>
<td>Yes – may require RIPA authorisation</td>
</tr>
<tr>
<td>Online activity</td>
<td>Systematically extracting or collecting information about a particular person or group.</td>
<td>Yes – may require RIPA authorisation</td>
</tr>
<tr>
<td><strong>Available to the GPhC and not requiring authorisation under RIPA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online activity – overt</td>
<td>General monitoring of the internet in circumstances where this is not part of specific, ongoing investigation to identify themes, trends, or other factors that may influence operational strategies.</td>
<td>No – unlikely to require RIPA authorisation</td>
</tr>
<tr>
<td>Online activity – overt</td>
<td>Searching a public database such as Companies House for information about a registered pharmacy.</td>
<td>No – unlikely to require RIPA authorisation</td>
</tr>
</tbody>
</table>
Online covert activity

We may use the internet for intelligence gathering and/or as a surveillance tool. Where online monitoring or investigation is conducted covertly for the purpose of a specific investigation or operation and is likely to result in the obtaining of private information about a person or group, an authorisation for directed surveillance should be considered.

In deciding whether online surveillance should be regarded as covert, consideration should be given to the likelihood of the subject(s) knowing that the surveillance is or may be taking place.

In order to determine whether a directed surveillance authorisation should be sought for accessing information on a website as part of a covert investigation or operation, it is necessary to look at the intended purpose and scope of the online activity it is proposed to undertake.

Factors that should be considered in establishing whether a directed surveillance authorisation is required include whether:

- the investigation or research is directed towards an individual or organisation;
- it is likely to result in obtaining private information about a person or group of people;
- it is likely to involve visiting internet sites to build up an intelligence picture or profile;
- the information obtained will be recorded and retained;
- the information is likely to provide an observer with a pattern of lifestyle;
- the information is being combined with other sources of information or intelligence, which amounts to information relating to a person’s private life;
- the investigation is part of an ongoing piece of work involving repeated viewing of the subject(s);
- it is likely to involve identifying and recording information about third parties, such as friends and family members of the subject of interest, or information posted by third parties, that may

<table>
<thead>
<tr>
<th>Online activity - overt</th>
<th>A simple internet search of a name, address or telephone number to find out if the person subject to an investigation has an online presence and an initial examination of that online profile to see if it is relevant to the investigation.</th>
<th>No - Unlikely to require RIPA authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overt activity</td>
<td>A GPhC inspector conducting an unannounced inspection to check that enforcement action such as an Improvement Notice or a Condition on Registration has been complied with.</td>
<td>No – this activity is not regulated under RIPA</td>
</tr>
</tbody>
</table>
include private information and therefore constitutes collateral intrusion into the privacy of these third parties.

Please read sections 3.10 to 3.17 of the Home Office Code of Practice for more information about online covert surveillance.
Appendix 1: RIPA Checklist – is authorisation required?

Prior authorisation by an Authorising Officer (Director) will be required for a proposed activity if the answer is 'Yes to all' of the following questions.

If the answer is 'No to any' of the following questions, the proposed activity falls outside the scope of RIPA.

Questions to ask yourself

1. Is the proposed activity 'surveillance'?
   The investigator/inspector must decide whether the proposed activity will comprise monitoring, observing or listening to persons, their movements, their conversations or their other activities or communications, recording anything monitored, observed or listened to in the course of the proposed activity and whether a surveillance device will be used.

2. Is it 'covert'?
   The investigator/inspector must decide whether the proposed activity will be carried out in a manner calculated to ensure that any person subject to the surveillance will be unaware that it is or may be taking place.

3. Is it conducted for the purposes of a specific investigation?
   The investigator/inspector must decide whether the proposed activity is for the purposes of a specific investigation or operation.

4. Is it likely to result in obtaining private information about this person?
   The investigator/inspector must decide whether any information about the subject’s private or family life is likely to be obtained. This applies whether or not one is identified for the purpose of the investigation or operation.

Remember, private information includes any information relating to a person’s family or private life.

5. Is it a 'foreseen/planned response'?
   The investigator/inspector must decide whether the proposed activity is something other than an immediate response to events. If the proposed activity has been planned in advance and is not just an immediate reaction to events happening in the course of the inspector’s work, it is not unforeseen and requires authorisation if all the answers to questions 1 to 4 have also been 'Yes'.

Please refer to the complete RIPA policy and procedures for further guidance on all of the above.
Appendix 2: Is a directed surveillance authorisation required?

Is the surveillance to be carried out in a manner calculated to ensure that the persons subject to the surveillance are unaware that it is or may be taking place?

- Yes: The surveillance is not covert and authorisation is not required
- No

Will the surveillance require the presence of an individual or use of a surveillance device on the subject’s residential premises, or private vehicle?

- Yes: This counts as ‘intrusive surveillance’ and cannot be authorised by the GPhC in accordance with RIPA
- No

Does the surveillance require the establishment of a personal or other relationship with another person in a covert manner (which excludes overt surveillance) to obtain, provide access to or disclose information as a consequence of the relationship?

- Yes: This amounts to the use of a CHIS and cannot be authorised by the GPhC in accordance with RIPA
- No

Is the surveillance planned as part of a specific investigation or operation?

- Yes
- No

Is information about a person’s private or family life likely to be obtained? (The likelihood of obtaining such information should be considered in its widest sense.)

- Yes: Authorisation for Directed Surveillance MUST be obtained
- No: Authorisation for Directed Surveillance is NOT required
DRAFT Appendix 3: Authorisation process flowchart

Requesting investigator/inspector (the applicant) **MUST**:
- Read the full RIPA policy and procedures and be aware of any other guidance
- Determine that directed surveillance is required
- Assess whether authorisation will be in **accordance with the law**
- Assess whether authorisation is **necessary** under RIPA and whether it could be done overtly
- Consider whether surveillance will be **proportionate**
- Assess the risk of **collateral intrusion** and describe measures to limit this
- If authorisation is approved – review regularly

If a less intrusive option is available and practicable, **use that option**

Authorising Officer **MUST**:
- Consider in detail whether all options have been duly considered
- Consider whether surveillance is considered to be **necessary and proportionate**
- Authorise only if an overt or less intrusive option is not practicable
- Set an appropriate review date (3 months after the authorisation date) and conduct the review – authorisations should be cancelled when no longer necessary.

The Applicant **MUST**:
- Complete and submit the review form on the date set

Authorising Officer **MUST**:
- (If surveillance is still necessary and proportionate) Review authorisation and Set an appropriate further review date

The Applicant **MUST**:
- If the operation is no longer necessary or proportionate, complete a cancellation form and submit to an Authorising Officer

Authorising Officer **MUST**:
- Cancel authorisation when it is no longer necessary or proportionate

**ESSENTIAL**
- Send both authorised and rejected forms to the RIPA Monitoring Officer **within one week** of the relevant event
Proporionate actions to the result you are seeking. Ask yourself: how intrusive will the proposed operation be on the subject and others compared to the good that will be achieved? Is the surveillance the right thing to do or might a court think your actions were unreasonable given the circumstances? Are there other less intrusive ways of gathering the information you need?

Lawful actions are supported by legislation. Is there any case law that supports what you propose to do? Have you read the relevant guidance and sought legal advice, if needed?

WHAT DOES THIS MEAN IN PRACTICE?

You must Account for your decisions. If you are taking action, is this the right thing to do? Have you made sure that anyone could see why you have decided to take the action and how you reached your decision?

It is not enough that your actions are proportionate; they must also be necessary to achieve the result you are aiming for. Will this evidence actually prove anything, is it strictly needed and will it add sufficient weight to your case to justify the intrusion?
### Notes for Applicants and Authorising Officers:
Please ensure that you read the complete RIPA policy and procedures before completing this application form.

### PART II OF THE REGULATION OF INVESTIGATORY POWERS ACT 2000

#### APPLICATION FOR AUTHORISATION TO CARRY OUT DIRECTED SURVEILLANCE

<table>
<thead>
<tr>
<th>PART 1: APPLICANT DETAILS</th>
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</thead>
<tbody>
<tr>
<td><strong>1.1 Name of applicant</strong></td>
<td>Record your name here. Do not record the name of the investigator/inspector carrying out the surveillance (unless that is you).</td>
</tr>
<tr>
<td><strong>1.2 Investigator/inspector</strong></td>
<td>If the person who is the investigator/inspector in the case is someone other than you, record their name here.</td>
</tr>
<tr>
<td><strong>1.3 Head of Function</strong></td>
<td>Please include the details of your Head of Function and ensure that they have approved your application before it is sent to the Authorising Officer (Director).</td>
</tr>
<tr>
<td><strong>1.4 Authorising Officer</strong></td>
<td>Please include the details of the Authorising Officer, who will be reviewing the application.</td>
</tr>
<tr>
<td><strong>1.5 Directed Surveillance Unique Reference Number</strong></td>
<td>This number will be provided by the RIPA Monitoring Officer. Please ensure that you have also sent a copy of your application form to the RIPA Monitoring Officer at the same time as your submission to the Authorising Officer.</td>
</tr>
<tr>
<td><strong>1.6 Date of application</strong></td>
<td>Please insert the date on which you are submitting your application to the Authorising Officer</td>
</tr>
</tbody>
</table>

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<tr>
<th>PART 2: APPLICATION DETAILS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1 Describe the purpose of the specific investigation/operation</strong></td>
<td>Enter a summary of the reason for the investigation or operation and what you are planning to do. Be brief: what will you do, why are you doing it and what will you get out of it?</td>
</tr>
</tbody>
</table>
2.2 Describe in detail the surveillance operation to be authorised and expected duration, including any equipment or monitoring devices that may be used.

You should include the methods you will use for the surveillance. What are the technical aspects? Who, what, when, where, how long, how many, equipment etc. You should mention everything as you will not be authorised carry out anything that you do not mention here.

2.3 Specify the identities, where known, of those to be subject to the surveillance.

Who are you intending to gather evidence on? If you do not know the identity of all subjects you must describe them as best as you are able.

2.4 Explain the information that you want to obtain from the surveillance.

What evidence do you intend to obtain from the surveillance? Specify exactly what you intend to get, how much and what types. From this, a judgement can be made as to the substance of the evidence that you will get. Be careful what you write here: **when you have achieved these aims the surveillance must stop immediately.**

2.5 Identify on which grounds the directed surveillance is necessary under section 28(3) of RIPA 2000.

The GPHC is only entitled to rely on the following three statutory grounds:

i. for the purpose of preventing or detecting crime or preventing disorder.
<table>
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<tr>
<th>ii.</th>
<th>in the interests of public safety</th>
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</thead>
<tbody>
<tr>
<td>iii.</td>
<td>for the purpose of protecting public health (for example, investigations into illicit sale of medicines).</td>
</tr>
</tbody>
</table>

Cross out the grounds that do not apply for this specific application.

### 2.6 Explain why the surveillance is necessary on the grounds you have identified

State why the information has to be obtained by surveillance, why do you need it for the reason you specified? How is it essential to the case?

### 2.7 Explain why the surveillance is proportionate to what you are seeking to achieve

This is where you must justify your actions as proportionate. You should have completed an investigation plan and decided that surveillance is necessary and the last resort. Record here what you have done already and what you cannot do as it will prejudice the investigation.

Tell the Authorising Officer why the need to carry out the action outweighs the subject's right to privacy. How serious is the matter? How intrusive will the operation be on the subject and on others? What might happen if you don't carry out surveillance? Why can't you get the information in other ways? What will be achieved by gathering the evidence?

### 2.8 Provide details of any potential collateral intrusion, why this is unavoidable and the steps that will be taken to minimise this

Collateral intrusion is where the operation interferes with the private lives of those not intended to be subject to the surveillance. This could be members of the suspect's family, their partners, colleagues or members of the public. You must identify where there is a risk that you will gather this sort of information. You must take steps to minimise this risk and show that the risk left is unavoidable: what times are you conducting surveillance? Can you avoid catching others on camera? Do you have facilities...
to remove identifying features? The Authorising Officer must be satisfied that the need to carry out the operation outweighs this risk.

2.8 CONFIDENTIAL INFORMATION – Indicate the likelihood of acquiring any confidential information

Confidential information consists of communications subject to legal privilege and confidential personal information. For example, confidential personal information is information held in confidence concerning an individual who can be identified from it, and the material in question relates to their physical or mental health.

If there is a chance that you might gather this sort of information, indicate the risk here. The authorisation can then only be given by the person within the GPhC designated by the RIPA code of practice for this purpose. This level of authorisation can only be given by the Chief Executive & Registrar.

Part 3: AUTHORISATION DETAILS

3.1 Authorising Officer’s statement

I hereby authorised directed surveillance as follows:

You must start by fully explaining what operation you are authorising. State why the surveillance is necessary to the case, what will be achieved, how it will be carried out, how many people used, what equipment/vehicles/technology you authorise the use of, and where the operation will happen. Make sure it is clear exactly what it is that you are authorising.

3.2 Explain why you think the directed surveillance is necessary and proportionate to what is being sought

Now you must explain your decision. Simply stating that you —agree with the officer who applied for the reasons they gave—is not acceptable. You must give, in your own words, a detailed account of how you came to decide that the operation was necessary on one or more statutory grounds, and proportionate to what you are seeking to achieve.

Make sure that you review the guidance in the GPhC RIPA policy on necessity and proportionality.

Now ensure that you demonstrate how the investigator/inspector has shown the need to obtain the evidence to be proportionate, when balanced against the subject's expectation of privacy, the privacy of third parties and the seriousness and extent of the offence or harm.
You must explain why you feel it is in the public interest to carry out the action; is the offence or harm serious, prevalent in the area, an abuse of position, premeditated? Why do you think that the investigation will be prejudiced without surveillance? Are you certain there is no other obvious and less intrusive way of obtaining the information? Does it need to be done? Record everything in this section.

Remember the authorisation will not be proportionate if it is excessive in the overall circumstances of the case. No activity should be considered proportionate if the information which is sought could reasonably be obtained by other less intrusive means.

**This section must stand on its own, if you are called to court to justify your authorisation.**

<table>
<thead>
<tr>
<th>3.3 Enhanced authorisations (where knowledge of confidential information is likely to be obtained)</th>
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</thead>
<tbody>
<tr>
<td>This section is to be completed <strong>only by the Chief Executive and Registrar</strong> if confidential information is likely to be obtained. They should explain why they felt it to be appropriate for the surveillance to be carried out. To comply with the Home Office codes, show how further measures, such as more regular reviews and stricter limitations, have been put in place due to the particularly sensitive nature of the operation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.4 Authorisation date</th>
<th>This is the date when the authorisation is granted</th>
</tr>
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</table>

| 3.5 Expiry date | This is always 3 months from the date that the authorisation was given as specified at 3.4 above, no longer and no shorter. The surveillance can be cancelled before this date, if appropriate (i.e. when it is no longer necessary). |

| 3.6 First review date | The normal review period is no longer than every four weeks. It doesn't have to be completed but is useful to do so, especially when a shorter review period is appropriate. |

**END OF APPLICATION AND AUTHORISATION FORM**

**Notes for Applicants and Authorising Officers:** Please ensure that you have returned copies of this application form to the RIPA Monitoring Officer
DRAFT Appendix 6: Monitoring, recording and handling information obtained under RIPA

1. All material obtained under the authority of a covert surveillance authorisation must be handled, retained, stored and destroyed in accordance with GPhC RIPA policies and procedures, the relevant legal framework and Home Office Codes of Practice, and relevant GPhC data protection and information security policies.

Handling and dissemination of materials

2. Material acquired through covert surveillance will need to be disseminated both within the GPhC and to other agencies, where necessary in order for action to be taken on it.

3. The number of persons to whom any of the information is disclosed, and the extent of disclosure, should be limited to the minimum necessary for the authorised purpose(s) set out below. In the same way, only so much of the material may be disclosed as the recipient needs; for example, if a summary of the material will suffice, no more than that should be disclosed.

4. Dissemination, copying and retention of material must be limited to the minimum necessary for authorised purposes. For example, where the material:
   - is, or is likely to become, necessary for any of the statutory purposes set out in the 2000 Act in relation to covert surveillance;
   - is necessary for facilitating the carrying out GPhC functions under the Act;
   - is necessary for facilitating the carrying out of any functions of the Commissioner or the Investigatory Powers Tribunal;
   - is necessary for the purposes of legal proceedings; or
   - is necessary for the performance of the functions of any person by or under any enactment.

5. It is important to note that there is nothing in the legislation which prevents material obtained under directed surveillance authorisations from being used to further other investigations where it becomes relevant and in accordance with relevant the safeguards.\(^1\)

6. Material obtained through covert surveillance may only be copied to the extent necessary for the authorised purposes set out above. Copies include not only direct copies of the whole of the material, but also extracts and summaries which identify themselves as the product of covert surveillance, and any record which refers to the covert surveillance and the identities of the persons to whom the material relates.

7. Information obtained through covert surveillance and all copies, extracts and summaries which contain such material should be scheduled for destruction and securely destroyed as soon as they are no longer needed for the authorised purpose(s) as set out at section 4 above.

---

\(^1\) Page 74 of the Home Office Code of Practice on Covert Surveillance and Property Interference
**Centrally retrievable records**

8. The GPhC must maintain a central register of all authorisations, refusals, reviews, renewals and cancellations for at least three years from the end of each authorisation in line with current Home Office guidance (see Covert Surveillance and Property Interference Code of Practice 2018, Chapter 8). The Home Office guidance indicates that it is desirable for records to be retained for up to 5 years, if possible.

9. Central records must be regularly updated whenever an authorisation is granted, renewed or cancelled. **Central records should include:**
   
   a. the type of authorisation (i.e. directed surveillance)
   
   b. the date the authorisation was given
   
   c. name and level (i.e. Director) of the authorising officer
   
   d. the unique reference number (URN) of the investigation or operation (*please note that this will be supplied by the RIPA Monitoring Officer when you submit your application for authorisation*)
   
   e. the case number of the investigation or operation, including a brief description and names of subjects, if known
   
   f. the dates of any reviews
   
   g. if the authorisation has been renewed, when it was renewed and who authorised the renewal, including the name and level of the authorising officer
   
   h. whether the authorised activity is likely to result in obtaining confidential or privileged information
   
   i. whether the authorisation was granted by an individual directly involved in the investigation
   
   j. the date the authorisation was cancelled.

10. The following documentation **should also be centrally retrievable for at least three years** from the ending of each authorisation:

   a. a copy of the application and authorisation form together with any supplementary documentation and notification of the approval given by the authorising officer
   
   b. a record of the period over which the surveillance has taken place
   
   c. the frequency of reviews prescribed by the authorising officer
   
   d. a record of the result of each review of the authorisation
   
   e. a copy of any renewal of an authorisation, together with the supporting documentation submitted when the renewal was requested
   
   f. the date and time when any instruction to cease surveillance was given
g. the date and time when any other instruction was given by the authorising officer

Please note that central records should be made available to the Investigatory Powers Commissioner’s Office (IPCO) and inspectors who support the work of the Commissioner upon request.

Staff responsibilities

RIPA Monitoring Officer

11. The RIPA Monitoring Officer (RMO) will maintain a central register of all authorisations, grants, refusals, reviews, renewals and cancellations in line with the requirements set out above. The role of the RMO includes:
   a. Keeping records of those allowed to grant authorisations
   b. Maintaining and updating the central records as set out above
   c. Liaising with and providing copies of all applications and authorisations to the information governance team, to consider any relevant privacy or wider data protection considerations
   d. Arranging and maintaining records of staff training
   e. Checking for updated advice (IPCO and Home Office website etc.) and circulating this to relevant staff
   f. Raising any concerns and potential problems or errors with the Authorising Officers and Senior Responsible Officer

Authorising Officers

12. Each Authorising Officer (Director) is personally responsible for reporting the following information to the RIPA Monitoring Officer as soon as possible and, in any event, within one working day:
   - Authorisation of directed surveillance
   - Review, renewal or cancellation of directed surveillance
   - Any unexpected deviations from normal practice or procedure
   - Any other relevant matter concerning the authorisation of surveillance

Recording and reporting errors

13. Proper application of the surveillance provisions in Part II of RIPA and related Home Office guidance should reduce the scope for errors.
14. When a relevant error\(^2\) has occurred, the GPhC must notify the Investigatory Powers Commissioner as soon as reasonably practicable, and no later than ten working days (or as agreed with the Commissioner) after it has been established by appropriate internal governance processes that a relevant error has occurred. Such internal governance processes are subject to review by the Investigatory Powers Commissioner.

15. Where the full facts of the error cannot be ascertained within that time, an initial notification must be sent with an estimated timescale for the error being reported in full and an explanation of the steps being undertaken to establish the full facts of the error.

16. Any staff member who is concerned about the appropriateness of an authorisation, or any other issue or concern about an authorisation, should notify the RIPA Monitoring Officer (RMO) as soon as this becomes apparent.

17. Please see Chapters 8.6 to 8.18 of the Home Office Code of Practice for more detailed information about reporting and acting on errors.

---

\(^2\) This includes compliance with Part II of RIPA. For example, a relevant error includes surveillance that has taken place without lawful authorisation.
Dear Chief Executive

IPCO Inspection Report – General Pharmaceutical Council (GPhC)

As you are aware, your organisation was inspected on the 10 May 2019 to examine the arrangements GPhC has in place to secure compliance with the legislative provisions which govern the use of covert surveillance. I am grateful to the assistance provided by your staff to my inspector, Paul Donaldson, whose report I attach and endorse.

Mr Donaldson has made a number of observations based on current policies, the processes you are developing in preparation for your organisation’s use of covert investigatory powers and to ensure compliance. Mr Donaldson has been notably complimentary in respect of these arrangements although he has highlighted some cautionary areas, in particular as regards online covert activity. I wish to stress that IPCO does not in any sense seek to deter GPhC from utilising these powers – quite the contrary – but instead we wish to help your organisation conduct lawful investigations.

It is highlighted that it is your praiseworthy intention to embark on a training programme for those staff who are to be engaged in RIPA activity, and that any covert activity will only be undertaken on completion of the programme. I support this approach: it will help ensure your organisation develops and maintains strong governance and compliance.

Regular and consistent internal review of the use of these powers should be managed through the Senior Responsible Officer and RIP A Coordinator. This includes ensuring that all necessary arrangements are in place in anticipation of their use in the future, and your officers need to maintain their levels of training. Although it may seem somewhat counter-intuitive, this requirement applies particularly if these powers are utilised sparingly. You have yet to resort to your powers under RIPA to conduct investigations via social media. These provide important investigative opportunities, but this activity must be controlled, auditable and readily understood. The Home Office Codes of Practice on Covert Surveillance and Property Interference and Covert Human Intelligence Sources provide some helpful advice.

I am grateful to the assistance provided during this inspection, especially from Ms Laura McClintock, Chief of Staff.
We look forward to revisiting your organisation in about 18 months’ time, to provide further support for the renewed use of these powers on-line. This is an important step which is in the public interest, and we will provide all possible assistance to help ensure compliance with the law.

Yours sincerely,

[Signature]

The Rt. Hon. Lord Justice Fulford
The Investigatory Powers Commissioner
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1 Introduction

1.1 This inspection was conducted to assess the level of compliance of this public authority with the Regulation of Investigatory Powers Act (RIPA) 2000 in respect of its use and management of directed surveillance. This is the only activity the organisation is entitled to undertake by virtue of the legislative change enacted through Statutory Instrument 2018/905, The Investigatory Powers (Codes of Practice and Miscellaneous Amendments) Order 2018.

1.2 This inspection took place on Friday 10 May 2019 and was conducted by Mr Paul Donaldson.

1.3 This report is addressed to Mr Duncan Rudkin, Chief Executive, General Pharmaceutical Council, 25 Canada Square (26th Floor), London E14 5LQ.

Duncan.Rudkin@pharmacyregulation.org.uk

2 Inspection methodology

2.1 The inspection methodology comprised of interviews with key members of staff identified as being responsible for discharging functions attached to the use of RIPA investigatory powers. The organisation has only recently had investigatory powers restored to it through SI 2018/905 and to date has not sought to undertake any covert activity requiring the protection of RIPA.

2.2 The last inspection of the organisation took place in February 2016 when, at that time, efforts were being made to rectify the anomaly of there being no legal basis for GPhC to undertake directed surveillance after re-organisation from the Royal Pharmaceutical Society of Great Britain. GPhC have developed draft policies and procedures in contemplation of the eventual use of the powers which have yet to be approved by the Senior Leadership Group.

2.3 This inspection report will focus on the work done thus far by GPhC in achieving a state of readiness for using any of the investigatory powers granted to it.

2.4 The draft policies viewed at this inspection are captured in Error! Reference source not found. below.

2.5 The persons interviewed during the inspection are captured in Table 2 below.

<table>
<thead>
<tr>
<th>Policies Examined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation of Investigatory Powers (RIPA) Policy (V1)- Draft</td>
</tr>
<tr>
<td>Appendix 1 – RIPA Checklist - Draft</td>
</tr>
<tr>
<td>Appendix 2 – Is RIPA authorisation required - Draft</td>
</tr>
<tr>
<td>Appendix 3 – Authorisation Process Chart - Draft</td>
</tr>
<tr>
<td>Appendix 4 – Guidance Notes (PLAN) - Draft</td>
</tr>
<tr>
<td>Appendix 5 – Application &amp; Authorisation, Guidance Notes - Draft</td>
</tr>
<tr>
<td>Appendix 6 – Monitoring, Recording and handling Information - Draft</td>
</tr>
</tbody>
</table>
Table 1. Policies Examined

<table>
<thead>
<tr>
<th>Persons Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duncan Rudkin, Chief Executive</td>
</tr>
<tr>
<td>Claire Bryce-Smith, Director of Insight, Intelligence and Inspection</td>
</tr>
<tr>
<td>Julian Graville, Head of Inspection</td>
</tr>
<tr>
<td>Laura McClintock, Chief of Staff</td>
</tr>
</tbody>
</table>

Table 2. Persons interviewed

3 Key findings

3.1 Recommendations

3.1.1 No recommendations were made as a result of this inspection.

3.2 Observations

3.2.1 The key observations arising from the inspection are listed in Table 3. below.

<table>
<thead>
<tr>
<th>Number</th>
<th>Reference</th>
<th>In relation to</th>
<th>Recommendation</th>
<th>Observation type</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1</td>
<td>5.1.1</td>
<td>Oversight</td>
<td>GPhC to consider who occupies the role of SRO.</td>
<td>Comment – observation</td>
</tr>
<tr>
<td>O2</td>
<td>5.1.4</td>
<td>Policy</td>
<td>Annex A – content containing examples of operational scenarios where RIPA may be engaged.</td>
<td>Comment – praise of good practice</td>
</tr>
<tr>
<td>O3</td>
<td>5.1.7 5.1.9</td>
<td>Policy</td>
<td>Inclusion of process charts to assist practitioners.</td>
<td>Comment – praise of good practice</td>
</tr>
<tr>
<td>O4</td>
<td>5.2.4</td>
<td>Emerging Issues</td>
<td>Research being conducted into emerging threat from abuse of online marketplaces.</td>
<td>Comment – praise of good practice</td>
</tr>
<tr>
<td>O5</td>
<td>5.3.2</td>
<td>Policy</td>
<td>Provide more clarity around parameters of online deployments where test purchases are being considered.</td>
<td>Comment - Observation</td>
</tr>
<tr>
<td>O6</td>
<td>5.3.3</td>
<td>Policy</td>
<td>Process of recording single test purchases where no RIPA authorisation exists.</td>
<td>Comment – praise of good practice</td>
</tr>
</tbody>
</table>
4 Actions taken on previous inspection recommendations

4.1 No recommendations were made at the last inspection conducted in 2016.

5 Inspection findings

5.1 Policy and Procedures

5.1.1 Currently Claire Bryce-Smith, Head of Insight, Intelligence and Inspection occupies the role of Senior Responsible Officer (SRO) whilst Duncan Rudkin, Chief Executive is the designated Authorising Officer. Whilst there is no prohibition on an SRO being less senior within the management structure of an organisation to that of Authorising Officer, it is suggested that to demonstrate good practice as per paragraph 4.41 it may for advisable for the SRO to be the person who occupies the more senior role within the organisation.

5.1.2 Since the relevant RIPA power (directed surveillance) was restored, GPhC has concentrated on developing and improving its policies, procedures and processes ahead of any consideration of using the power. This approach, coupled with the recognition of the need for appropriate training (paragraph 5.5.1) to be delivered to those identified as being designated persons in the RIPA process, is eminently sensible to ensure that a robust governance and compliance regime is set prior to any activity being undertaken.

5.1.3 In discussions with staff they clearly view this as the priority and were very enthusiastic as part of this inspection to seek the views of the inspector in relation to the work completed thus far in developing their governance regime. To that end the policies and processes were provided to the inspector ahead of his physical visit.

5.1.4 The RIPA Policy V1 (Draft) is a very comprehensive document, and despite running to 16 pages, is well constructed and easy to read, containing the relevant detail pertaining to the ability to authorise and deploy directed surveillance. The policy also refers to other RIPA powers not available to GPhC (Intrusive Surveillance and CHIS), clearly highlighting them as being unavailable, and providing examples within Annex A of the type of activity which would meet the definition of each. This is most helpful to practitioners in ensuring they can compare what they may propose to use as an investigative tool to those examples, which should assist with the organisation’s proposed governance and compliance regime.

5.1.5 Within Annex A clear examples are given of a range of operational scenarios which may engage the requirement for operatives to seek the protection of RIPA. It is suggested that to further bolster the document, relevant signposts to the Codes are also included where further examples are illustrated for the benefit of practitioners.

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1 Home Office Revised Code of Practice, Covert Surveillance and Property Interference, August 2018
2 Home Office Revised Codes of Practice, Covert Surveillance and Property Interference, August 2018 and Covert Human Intelligence Sources, August 2018
5.1.6 In paragraph 6.10 of the draft policy there is reference to Health and Safety obligations being attached to Authorising Officers in respect of their authorising directed surveillance. This is not a requirement placed on them by either the legislation or the Code of Practice, and neither is there a requirement for any Risk Assessment to be completed in respect of directed surveillance. This is more an issue for those undertaking the activity, although if GPhC decides on these risks being attached to the application as part of its Organisational Policy then it is at its discretion. It may be beneficial to make that clear in the policy.

5.1.7 Several appendices are attached to the draft policy which contain process and decision flow charts outlining the actions to be adopted by practitioners when considering the use of covert tactics, and what is required when preparing and submitting applications for the consideration of Authorising Officers. These were found to be especially helpful to practitioners and evidence of good practice.

5.1.8 In Appendix 3 (Authorisation Process Chart) in relation to what considerations require to be made by Authorising Officers, there is an omission of the requirement to consider the risk of collateral intrusion. It is advised that this is included at the relevant section, and it would also be helpful to remind Authorising Officers to clearly articulate in any authorisation the specific conduct they are authorising to ensure that operatives can discharge their R v Sutherland responsibilities.

5.1.9 Appendix 4 was found to be a particularly good document which provides a checklist for an applicant to work through in the form of four categories (PLAN): Plan, Lawful, Accountable and Necessary. The questions for operational staff to ask themselves provides an additional layer of governance which demonstrates the attitude this organisation has to compliance and is evidence of good practice.

5.1.10 GPhC has also produced a policy (Appendix 6) in relation to the management of material obtained through RIPA activity and the responsibilities attached to those involved in the authorisation process. It also describes where and how the documentation and material will be recorded and is wholly compliant with Section 8 of the Code.

5.2 Directed Surveillance

5.2.1 It is evident that many of the issues subject to GPhC’s inspection and investigations, where concerns are raised around pharmacists and pharmacies, would benefit in certain circumstances from the deployment of directed surveillance tactics. Whilst the intelligence and traditional inspection functions within the organisation are mature, changes in the strategic issues faced as part of its regulatory function may result in the reduction of the effectiveness of these more traditional inspection and investigative techniques.

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3 Home Office Revised Code of Practice, Covert Surveillance and Property Interference, August 2018
5.2.2 One such emerging issue is the increased use of digital technology in the procurement and supply of pharmaceuticals, their diversion away from legitimate markets and the increase in monetary value, as well as the increase in reporting of fitness to practice concerns - all have potential implications to the efficacy of GPhC investigations. It is worthy of note that the increase in concerns related to a pharmacist’s fitness to practice is averred to be linked to the increase in public awareness of the issue and in relevant reporting mechanisms.

5.2.3 It is acknowledged by GPhC that whilst many of its investigations into such matters can be resolved using overt investigative solutions, the advent of a significantly greater online marketplace and cyber enabled criminality has the potential to make traditional forms of inspection and investigation less effective.

5.2.4 In that regard GPhC has identified the need to ensure that it has the capacity and capability to respond to the changing online landscape and will embark on an information gathering exercise to assess its operational requirements in the future. Some suggestions of organisations were provided where it may be able to conduct some initial enquiries.

5.3 Covert Human Intelligence Sources (CHIS)

5.3.1 Whilst GPhC did not seek restoration of previous powers afforded to its predecessor organisation to authorise CHIS, in discussion with staff involved in the inspection and intelligence arenas there appeared to be areas where the deployment of CHIS for the purpose of test purchasing online may in the future be operationally beneficial. Given the vast increases in cyber enabled and cyber dependent criminality, and the range of regulatory activities GPhC is undertaking, situations can be envisioned where repeated purchases may require to be made to reach an evidential threshold.

5.3.2 It is accepted that not all test purchases, particularly those made on a single occasion by a public authority while discharging its legislative responsibilities, will require the protection of RIPA as highlighted by Sir David Clarke in his OSC inspection of GPhC in 2013 (paragraphs 20 to 22). That said, circumstances may present themselves in the future where it may require going beyond that, and GPhC will need to provide more clarity in its draft policy (page 14) of the parameters it must operate within when online test purchases are considered, and that a CHIS authorisation would be required.

5.3.3 In the OSC Inspection Report of 2016 it was highlighted as good practice that when any test purchases were made, the reasons for not seeking the protection of RIPA were recorded with a clear rationale supporting this decision being articulated. This process remains in place and should continue.

5.3.4 The advent of technical solutions to the acquisition and provision of pharmaceuticals on online marketplaces offers additional opportunities for cyber enabled and cyber dependent criminality within areas regulated by GPhC. Situations can quite easily be envisioned where repeated purchases or deployments online may require to be made to reach an evidential threshold and enable enforcement or intervention outcomes to be achieved. This was discussed with staff and the solution which is currently open to
GPhC, dependent on the nature of the ‘criminality’ or the potential for a multi-agency investigation, would be to potentially seek the assistance of a partner agency with recourse to the authorisation of a CHIS for further purchases to be made.

5.3.5 Whilst there being no suggestion or real appetite to seek any legislative change, it may be a worthwhile exercise for GPhC to engage with relevant partners to conduct research into these types of CHIS deployments, particularly online, where future operational benefits may be afforded to GPhC.

5.4 Online Activity

5.4.1 Whilst there has been no covert online activity undertaken, it was opined that inspectors will often conduct internet research as part of their investigations and do so within clearly defined parameters which are contained within Annex A of the Draft Policy. Examples are given within the document, although it may be helpful for practitioners to be signposted to the Code of Practice4 which provides guidance at sections 3.10 to 3.17.

5.4.2 The issue of online interaction was discussed at length and, save to repeat the contents of Section 5.3, it was indicated by staff that the intention was to engage with similar organisations to benchmark what investigative activity is regularly being undertaken online as a means of developing any opportunities which may be available within GPhC investigations. This is viewed as a worthwhile exercise and some illustrations were provided to staff of the type of activity that would be beneficial to them.

5.4.3 The processes in place for the management of online research were found to be compliant.

5.5 Training

5.5.1 Given that the powers have only relatively recently been returned to GPhC, senior management have intimated that they will embark on a new programme of training to ensure their staff in relevant RIPA roles are adequately trained for their role and are current in respect of knowledge and training. GPhC will seek to identify the most appropriate means of providing the required training and will include this as part of any action plan devised as a result of the observations made in this inspection.

5.5.2 It would be advisable for GPhC to prioritise the delivery of appropriate training to ensure those within the organisation involved in RIPA activity are fully aware of the obligations and responsibilities placed upon them.

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4 Home Office Revised Code of Practice, Covert Surveillance and Property Interference, August 2018
6 Conclusion

6.1 As highlighted previously, GPhC has only recently had the RIPA power of directed surveillance reinvested to it in November 2018 and to date has not used any of that power. In discussions with senior management it is clear they see avenues within investigations where recourse to covert tactics would no doubt benefit some of their investigations. The nature of their regulatory inspections and investigations are such that less intrusive overt methods of enquiry tactics very often bring about the objectives sought, although it is recognised that the threat of cyber enabled criminality within areas regulated by them is a potential threat meriting some focus.

6.2 The organisation has been preparing itself well in advance of considering the use of covert investigative methods and is definitely on track to establishing a robust and intrusive governance regime and therefore compliant with the legislation and codes of practice. I would though recommend that GPhC are subject to an inspection within the next 18 months to ensure that this momentum is maintained.

6.3 I would like to thank Duncan Rudkin and his team for accommodating this inspection, especially Ms Laura McClintock who very efficiently set up the necessary arrangements to achieve it.

Paul Donaldson
IPCO Inspector
Minutes of the Audit and Risk Committee meeting held on Wednesday 17 July 2019 at 25 Canada Square, London at 10:00

TO BE CONFIRMED 24 October 2019

Minutes of the public session

Present

Digby Emson (Chair)
Helen Dearden
Aamer Safdar
Jayne Salt

Apologies

Rima Makarem

In attendance

Duncan Rudkin (Chief Executive and Registrar)
Jonathan Bennetts (Associate Director of Finance and Procurement)
Pascal Barras (Risk and Assurance Manager)
Janet Collins (Governance Manager)
Ashley Norman (TIAA)
Thanzil Khan (TIAA)
Bill Mitchell (BDO) Items 1-5

1. Attendance and introductory remarks

1.1 The Chair welcomed those present to the meeting, particularly Aamer Safdar who was new to the committee and Ashley Norman and Thanzil Khan of TIAA who were attending their first meeting as the GPhC’s internal auditors. Apologies had been received from Rima Makarem.
2. **Declarations of interest**

2.1 Members were asked to declare any interests at the start of each item.

3. **Minutes of the last meeting**

3.1 The minutes of the public session of the meeting held on 22 May 2019 were agreed as a true and accurate record.

4. **Actions and matters arising**

4.1 Action 6.5 from January 2019 – the fire risk assessment had been carried out in July 2019 and recommendations were being produced.

4.2 From May 2019, action 5.9 was not yet due and action 5.18 would be covered during the meeting.

4.3 Under matters arising, Jonathan Bennetts (JB) noted in relation to paragraph 9.4 of the May minutes that an assurance review of the procurement function was not needed given that an audit was planned.

5. **Internal audit report**

5.1 Pascal Barras (PB) presented _19.07.ARC.01_ which provided the quarterly report to the committee on the progress of the internal audit plan and the follow-up of recommendations.

5.2 A total of 50 recommendations had been made through the delivery of the 2018-19 audit plan, seven at priority one, 30 at priority two and 13 at priority three. To date, 25 of those recommendations had been implemented, including six at priority one.

5.3 Limited work had been planned for Q1 owing to the change of internal audit service provider and there was only one internal audit to report. This was presented by Bill Mitchell of BDO.

_FtP Decision making threshold criteria_

5.4 This report followed the revision of the threshold criteria used in FtP for deciding whether to refer cases to the Investigating Committee. The revisions were prompted by the introduction of new standards for pharmacy professionals and to allow case officers to apply a more contextual and judgement-based approach.

5.5 The audit looked at how the new criteria were being applied in practice after they had been in operation for one year. The key considerations were:

- whether the new criteria were being correctly and consistently applied;
• whether there was sufficient management oversight to ensure consistent application; and

• whether staff were appropriately and sufficiently trained to apply the criteria effectively.

5.6 The audit gave a green/amber rating. Positive aspects included good procedures and guidance to support consistent application of the criteria and monthly meetings to share learning. Areas for development included a need for more induction and ongoing training for staff, a training log and a delay in undertaking a routine audit of cases closed or referred. However, the PSA was currently undertaking such an audit as part of its review.

5.7 The committee agreed that this was a good report.

5.8 The committee:

i) noted the Q1 2019/20 internal audit plan progress; and

ii) noted the GPhC’s performance in implementing the agreed recommendations.

5.9 The Chair thanked Bill Mitchell and his team on behalf of the committee and the GPhC for the service provided during the time that BDO (previously Moore Stephens) had acted as the internal auditors, particularly their professionalism and constructive criticism. Duncan Rudkin echoed the thanks on behalf of the staff team and noted that BM and his colleagues had helped to engender a culture change at the GPhC with regard to risk.

Bill Mitchell left the meeting

6. Internal audit charter

6.1 Ashley Norman (AN) presented the internal audit charter which set out the framework for the conduct and delivery of internal audit services provided by TIAA for the GPhC. It defined internal audit’s purpose, authority, responsibility and position within the organisation.

6.2 It was noted that a minor amendment would be needed as the Chief Executive of the GPhC is not the Accountable Officer as stated in the Charter.

6.3 The levels of assurance used by TIAA (green – substantial assurance; yellow – reasonable assurance; amber – limited assurance; and red – no assurance) were different from the five levels used by BDO (green, green/amber, amber, amber/red, red) but TIAA would make comparisons in their early audits to facilitate the change. The four areas had clear definitions and so this would be a beneficial change once everyone became familiar with it.

6.4 There would be a portal with a live tracking system. Access would be given to the Risk Manager first and then decisions taken about extending it to other staff. GPhC staff would be able to indicate on the portal that recommendations had been implemented but only TIAA would be able to close them once they had confirmation.
6.5 Updates would be provided at each ARC meeting. These could be the full list of recommendations, those due, coming due, overdue and/or recently closed. It was agreed that the first reports would include all the available information and the committee would decide from there what was the most useful.

6.6 JB would work with the GPhC Internal Communications Manager to develop a small communications plan around the change to new auditors.

6.7 The committee approved the internal audit charter subject to minor amendments.

7. Internal audit strategy, annual plan 2019/20 and transition update

7.1 Ashley Norman (AN) and PB presented this item, covering the plan for the next year and how the transition between internal audit providers would be managed. TIAA would take the BDO plan into account but would also carry out their own audit needs assessment for the GPhC. Meetings would take place with members of the SLG in the week beginning 22 July as part of the process. A revised plan would be circulated to the committee before the October meeting.

ACTION: JB

7.2 The internal audit opinion which needed to be provided at the end of each financial year would be provided by TIAA for 2019/20 as they would have carried out work in three of the four quarters and would follow up on the recommendations in the FtP audit previously discussed, which would be the only audit to have been carried out by BDO during the period in question.

8. Any other public business

8.1 JB raised the question of whether the external auditors should attend every meeting of the committee. It was agreed that it would be useful for them to attend as a matter of course, only not doing so by exception if the business had no relevance.

ACTION: JB

9.5 There being no further public business to discuss, the meeting closed at 11.05.

Date of the next meeting:
Thursday 24 October 2019