

## Council meeting

25 Canada Square  
Thursday, 10 March 2022

### Public business

- |     |   |                              |
|-----|---|------------------------------|
| 1.  | <b>Attendance and introductory remarks</b>  | Nigel Clarke                 |
| 2.  | <b>Declarations of interest – public items</b>  | Nigel Clarke                 |
| 3.  | <b>Minutes of the December meeting</b><br><i>Minutes of the public session on 10 February 2021</i>                                      | Nigel Clarke                 |
| 4.  | <b>Matters arising</b>  | Nigel Clarke                 |
| 5.  | <b>Workshop summary – February meeting</b><br><i>For noting</i>   | Nigel Clarke                 |
| 6.  | <b>Independent prescribing – consultation report</b><br><i>For noting</i>   | 22.03.C.01<br>Mark Voce      |
| 7.  | <b>Equalities guidance for pharmacy owners</b><br><i>For approval for consultation</i>  | 22.03.C.02<br>Annette Ashley |
| 8.  | <b>Post-registration assurance of practice</b><br><i>For noting</i>   | 22.03.C.03<br>Mark Voce      |
| 9.  | <b>Communications and engagement update</b><br><i>For noting</i>  | 22.03.C.04<br>Rachael Gould  |
| 10. | <b>Chair deputising arrangements 2022/23</b><br><i>For noting</i>   | 22.03.C.05<br>Janet Collins  |
| 11. | <b>Committee memberships 2022/23</b><br><i>For approval</i>   | 22.03.C.06<br>Janet Collins  |
| 12. | <b>Minutes of the Audit and Risk Committee</b><br><i>Minutes of the public items considered on 7 December 2021</i><br><i>For noting</i> | 22.03.C.07<br>Neil Buckley   |
| 13. | <b>Any other business</b>   | Nigel Clarke                 |

## Confidential items

- |   |                            |
|---|----------------------------|
| <b>14. Minutes of the February meeting</b><br><i>Minutes of the confidential session on 10 February 2022</i>                                      | Nigel Clarke               |
| <b>15. Minutes of the Audit and Risk Committee</b><br><i>Minutes of the confidential items considered on 7 December 2021</i><br><i>For noting</i> | 22.03.C.09<br>Neil Buckley |
| <b>16. Any other confidential business</b>  | Nigel Clarke               |

## Date of next meeting

Thursday 14 April 2022

# Minutes of the Council meeting held on 10 February 2022

*To be confirmed 10 March 2022*

## Minutes of the public items

### Present:

Nigel Clarke (Chair)  
Mark Hammond  
Ann Jacklin  
Jo Kember  
Elizabeth Mailey  
Rima Makarem

Penny Mee-Bishop  
Arun Midha  
Rose Marie Parr  
Aamer Safdar  
Jayne Salt  
Selina Ullah

### Apologies:

Yousaf Ahmad

### In attendance:

Duncan Rudkin	Chief Executive and Registrar
Carole Auchterlonie	Director of Fitness to Practise
Jonathan Bennetts	Director of Adjudication and Financial Services
Claire-Bryce Smith	Director for Insight, Intelligence and Inspection
Laura McClintock	Chief of Staff and Associate Director of Corporate Affairs
Gary Sharp	Associate Director of HR
Mark Voce	Director of Education and Standards
Professor Andy Husband	Chair of the Board of Assessors
Liam Anstey	Director for Wales
Laura Fraser	Director for Scotland

Vanessa Clarke	Head of Finance and Procurement
Damian Day	Head of Education
Julian Graville	Head of Inspection
Sarah Stein	Head of Registration
Carole Gorman	Governance and Assurance Manager
Janet Collins	Senior Governance Manager

## **1. Attendance and introductory remarks**

- 1.1 The Chair welcomed those present to the meeting. Apologies had been received from Yousaf Ahmad.

## **2. Declarations of interest**

- 2.1 The Chair reminded members of the Council to make any appropriate declarations of interest at the start of the relevant item.

## **3. Minutes of the last meeting**

- 3.1 The minutes of the public session held on 9 December 2021 were confirmed as a true and accurate record of the meeting.

## **4. Actions and matters arising**

- 4.1 There were no matters arising.

## **5. Workshop summary**

- 5.1 The summary of the workshop held on 9 December 2021 was noted.

## **6. Common registration assessment:**

### **Report of the November 2021 sitting and overview of the 2021 assessments (22.02.C.01)**

- 6.1 Professor Andy Husband, Chair of the Board of Assessors, joined the meeting to present the overview. A significant amount of work had been needed to get the assessment running during the pandemic and Professor Husband thanked the team and the Board for all their hard work. The Board was confident that the question papers had been robust and there had been no problems in running the same assessment with the Pharmaceutical Society of Northern Ireland (PSNI). There would be some challenges in using the data for comparative purposes as the 2021 cohort had been unique.
- 6.2 There was a disparity again in pass rates between trainees who had done their pre-registration training in hospital and those who had done it in community pharmacy. There was a need to understand the interplay between this, the attainment gap between students of different ethnicities and the impact of other protected characteristics.

- 6.3 It would be beneficial to have a provider with whom the Board and the team could build a longer-term working relationship.
- 6.4 **The Council noted the candidate performance data at Appendix 1; and the Board of Assessors' report to the Councils of the GPhC and the PSNI at Appendix 2 and the assurance it provided about the November 2021 sitting.**

*Professor Husband left the meeting*

#### **Delivering the registration assessment in 2022 (22.02.C.02)**

- 6.5 Mark Voce (MV) introduced the second paper on the registration assessment which updated the Council on the plans for delivery in the current year.
- 6.6 The date of the June sitting (29 June 2022) had been published and the autumn date had been agreed and could now be confirmed as 3 November 2022. Communication with candidates was underway and information had been published on the website.
- 6.7 The delivery of the assessment would be via the provider's (BTL Group Ltd.) network of secure test centres. There was sufficient capacity to deliver the assessment to all candidates on one day. Candidates should be able to sit in a test centre within reasonable travelling distance of their home, retaining the benefits in terms of cost and convenience when compared to the pre-pandemic model.
- 6.8 It was not proposed that candidates should be offered the opportunity to sit the assessment remotely. There were a number of reasons for this, including candidate feedback from 2021, the reduced risk of technical failures and the practical benefits to candidates such as the ability to take comfort breaks if needed. However, MV sought Council's feedback on this position.
- 6.9 All candidates granted reasonable adjustments, such as those needing extra time or a separate room, could be accommodated in the test centres and therefore would not need to sit remotely. Candidates who were based overseas should be in the U.K. at the end of June as the assessment would take place at the end of their training year.
- 6.10 Given that the pandemic situation could change and there was a possibility that some candidates in the U.K. could be required to self-isolate or be prevented from travelling due to specific restrictions, it was agreed there should be a contingency for remote sittings in those very limited and specific circumstances and that sitting at a BTL test centre would be the norm.
- 6.11 **The Council:**
- i. **noted the plans for delivering the summer and autumn common registration assessments in 2022; and**
  - ii. **agreed that remote sittings should be permitted as a contingency only in very limited and specific circumstances.**

## 7. Finance update, annual plan progress report and performance monitoring reports for Quarter 3 of 2021/22 (22.02.C.03)

### Performance Monitoring Report

#### *Customer Contact Centre (CCC)*

- 7.1 Sarah Stein (SS) joined the meeting to present the performance data for the CCC. The improvement in performance had continued, with all KPIs met and the direction of travel was still positive. All emails had been actioned within two days, calls had been answered in an average of 25 seconds and only 121 calls had been abandoned, from a total of 9,686. This had been achieved in the peak renewal period for most registrants and over the time of the third registration assessment.
- 7.2 SS also introduced the registration data. There had been a slight increase in processing times (13 days to 18) due to an increased workload but KPIs were still being met.
- 7.3 The Council welcomed the continued positive performance in the CCC and the registration applications teams.

#### *Fitness to Practise*

- 7.4 Carole Auchterlonie briefly introduced the FtP data, which continued to fall short of meeting most KPIs. The team had been focussing on older cases and faced challenges caused by sickness absence and seasonal leave. It was agreed that FtP performance would be discussed in more detail under item 10.

#### *Inspection*

- 7.5 Julian Graville introduced the performance data on Inspection. Performance had remained good with both standards met and improvements made during the first two quarters maintained. Five enforcement notices had been issued, four placing conditions on the registration of the pharmacies concerned and one Improvement Notice.
- 7.6 Inspectors continued to support pharmacies with 203 joint readiness visits with NHSE&I and follow-up calls to pharmacies delivering vaccination services during phase three of the rollout.

#### *Corporate complaints*

- 7.7 Laura McClintock introduced the data on corporate complaints. Numbers had risen slightly in Q3 but were still low. All KPIs had been met and the learning identified from a small number of complaints had been shared with relevant teams.

#### *Information governance*

- 7.8 Carole Gorman introduced the data on information governance. Performance had improved and all standards had been met, with all freedom of information and data subject requests responded to within the required time and no reportable information security breaches.
- 7.9 Quarter two had seen the delivery of the second sitting of the online registration assessment and the tender had been issued to run the assessment in 2022 and beyond. The pandemic had

affected planning by producing new work which had not originally been forecast but the outcomes due by 2025 were mostly on track.

#### *Human Resources*

- 7.10 Gary Sharp presented the HR data, where overall performance in Q3 was green. The absence rate had reduced but more staff had left than in the comparable quarter in 2020/21. This was not unexpected and a similar pattern was being seen across many organisations as people began to move jobs as pandemic restrictions were lifted. Turnover was expected to increase again in Q4.

#### **Finance update**

- 7.11 Vanessa Clarke presented the Q3 finance update. The Q3 reforecast anticipated a higher operational surplus than had originally been forecast, rising £0.58m to £1.34m. This was primarily due to a decrease in forecast expenditure of £0.74m, offset by a slight fall in predicted income of £0.08m (less than 0.5%).
- 7.12 The lower expenditure forecast cut across all categories and was attributed to delays and cancellations of activities (some of which would take place in 2022/23 and continued changes to the ways that services were delivered during the pandemic.
- 7.13 The investment portfolio had continued to perform well, though was still subject to ongoing volatility. The short-term position of the fund was not factored into the ongoing annual operational financial reporting.

#### **Annual plan progress report (APPR)**

- 7.14 Heather Walker presented the APPR. Progress had been positive, with all but three of the expected outcomes under the five strategic aims achieved. There had been a slight delay in the awarding of the contract for the registration assessment but the new supplier was now in place. The initial technical build of the new website had taken longer than anticipated but was due to be complete in Q4. While work had progressed on increasing security access to the IT infrastructure and systems, multi-factor authentication was not now expected to be switched on until Q4.
- 7.15 **The Council noted:**
- i. **the key areas of performance as highlighted in the cover paper**
  - ii. **the performance monitoring report, finance update and APPR.**

#### **8. Updated Strategic Plan 2020-25, year three (22.02.C.04)**

- 8.1 Duncan Rudkin introduced the paper. This was the third year of the five-year strategic plan to deliver the Vision 2030 for safe and effective pharmacy care at the heart of healthier communities. The strategic plan was submitted annually to the Privy Council to be laid before Parliament and the Scottish Parliament; and was also sent to the Senedd. The updates were set out in Appendix 1 to the paper.

## 8.2 The Council:

- i. **agreed that the current Strategic Plan 2020-25 should be updated with the revisions outlined in the paper and as set out in Appendix 1; and**
- ii. **agreed the Strategic Plan 2020-25 (year three) as set out in Appendix 2.**

## 9. Annual plan and budget 2022/23 (22.02.C.05)

- 9.1 Claire Bryce-Smith presented the annual plan for 2022/23. As noted in the previous item, this was the third annual plan drawn from the Strategic Plan 2020-25. In setting the corresponding budget, medium-term plans were also taken into consideration. Success measures were also included.
- 9.2 VC introduced the draft budget, which proposed an operating deficit of £0.53m. The last two years had been positive from a financial perspective, with a modest surplus in both years, but had also been full of challenges. A number of projects had been delayed or postponed and much of the proposed deficit would be funded from the resulting savings.
- 9.3 Income in 2022/23 was expected to be £26.5m – a £1.4m increase on the most recent forecast income for 2021/22. This was due largely to new pharmacists being expected to join the register at pre-pandemic levels and the full year impact of the April 2021 rise in premises fees. Full details were set out in the paper. Expenditure was expected to be £27.2m – a 14.4% increase on the current projected spend for 2021/22 and a 9.5% increase on the original budgeted expenditure for the year. Inflation and other cost increases had driven up the business-as-usual cost base and a proportion of the increase was a result of spending being depressed during the two years of the pandemic.
- 9.4 Other factors contributing to the higher expenditure included a number of key strategies reaching the implementation stage and therefore requiring resource, new areas of work requiring additional resources and the increased costs of supporting increasingly complex demands reflecting changes in the pharmacy sector.
- 9.5 The budget had been scrutinised by the Finance and Planning Committee. As the organisation settled into the ‘new normal’ ways of working it would be necessary to look again at the triangle of fees, investment and efficiency. The Council would be looking for clear benefits resulting from the increased spend.
- 9.6 Inflation in costs had been included in the proposals, as had an increase in National Insurance contributions. It was not possible to be accurate about the level, but the impact of higher than expected rises should not be too great.
- 9.7 **Following discussion, the Council:**
- i. **agreed the Annual Plan 2022/23 as set out at Appendix 1 of the paper; and**
  - ii. **approved the 2022/23 budget as set out in Appendix 2.**



## 10. Professional Standards Authority: annual performance review 2020/21 (22.02.C.06)

- 10.1 DR summarised the paper and noted a correction to paragraph 6.2, namely that the next review would cover the period March 2021 to June 2022.
- 10.2 The GPhC had met all the general standards of good regulation relating to information provision, EDI, performance reporting, corporate complaints, the application of policies and addressing learning. All the standards relating to guidance and standards; education and training; and registration had also been met but only two out of the five standards relating to FtP. However, the PSA had acknowledged that there had been improvements in relation to each of the three unmet standards, that the direction of travel was positive and that some of the improvement work being done in this area had been delayed by the pandemic.
- 10.3 Carole Auchterlonie noted that some factors which had arisen during the pandemic were still impacting on case progression, including delays at other agencies which had been similarly affected. Timeliness continued to be an issue and had been below what was hoped for at triage in Q3 (7.8 days as opposed to the KPI of five days). This had been affected by seasonal absences. Capacity issues were expected to show improvement in Q4 of the current year and Q1 of the next. The continued focus on old cases was felt to be the right way forward but also meant that timeliness would not improve in other areas.
- 10.4 Productivity in FtP had increased. Case administrators had been recruited to reduce the administrative load on case officers. The new Head of Continuous Improvement would monitor and evaluate the impact of changes as well as carrying out an end-to-end review of the current process.
- 10.5 The PSA had also been concerned about customer service. Staff had received further training, with an increased focus on a person-centred approach and the importance of giving regular updates (where that was what the parties wanted). While it was not clear exactly what needed to be done to meet the PSA standards, it was known that timeliness was likely to continue to be an issue in the next report as a significant portion of the review period had already passed.
- 10.6 **The Council noted the outcome of the 2020/21 performance review.**

## 11. Minutes of the Audit and Risk Committee (22.02.C.07 and 08)

- 11.1 **The Council noted the minutes of the public items considered at the Audit and Risk Committee meetings on 3 August and 21 October 2021.**

## 12. Any other business

- 12.1 Covid restrictions in England, Scotland and Wales permitting, the next meeting would be held in person at 25 Canada Square.
- 12.2 There being no further business, the meeting closed at 3.10 p.m.

## **Council workshop summary**

### **Meeting paper for Council on 10 March 2022**

Public

#### **Purpose**

To provide an outline of the discussions at the Council workshop on 10 February 2022.

#### **Recommendations**

The Council is asked to note the discussions from the February 2022 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 February 2022 workshop**

##### **GPhC approach to accreditation**

- 2.1 Mark Voce outlined the evolving process for accrediting education and training bodies who offer GPhC regulated qualifications. The correlation between the accreditation process and registration assessment results was explored. Whilst work on strengthening the accreditation process had enabled a greater focus on EDI and learner attainment, the limitations of current evidence and data were noted.

##### **EDI action plan**

- 2.2 Laura McClintock presented the EDI action plan drawn from the overarching EDI strategy. The action plan included a range of actions for GPhC to undertake as a regulator and as an

employer. Members were invited to share feedback on the plan and the intended success measures.

#### **Covid vaccination**

- 2.3 Duncan Rudkin shared the draft statement outlining the GPhC's position on pharmacy professionals being vaccinated against Covid-19, following the letter from the Secretary of State for Health and Social Care. Feedback and suggested amendments were provided prior to imminent publication of the statement.

#### **Accommodation**

- 2.4 Jonathan Bennetts provided an update on the accommodation strategy as discussions with Citigroup and communications with internal staff continued.

### **3. Recommendations**

The Council is asked to note the discussions from the February 2022 workshop.

Alex Dourish, Governance Manager  
General Pharmaceutical Council

03/03/2022

# Analysis of responses to consultation on independent prescribing

## Meeting paper for Council on 10 March 2022

Public business

### Purpose

To update Council on the analysis of the recent consultation on independent prescribing standards for pharmacists.

### Recommendations

Council is asked to:

- Note the analysis at **Appendix 1**
- Note the next steps

### 1. Introduction

- 1.1 On 28 September we launched a consultation on changes which would enable more pharmacists to begin their independent prescriber training.
- 1.2 The consultation sought views on proposals to remove the requirements for registered pharmacists to have two years of clinical practice, and to have relevant experience in a specific clinical or therapeutic area, before they can enrol on an accredited independent prescribing course. Views were also sought on retaining the requirement for course participants to identify an area of clinical or therapeutic practice as the basis of their learning and in which to develop their practice.
- 1.3 These changes would help meet the demand for more pharmacist independent prescribers from health services and patients. Current registered pharmacists and newly-qualified pharmacists joining the register over the next few years would be able to begin an independent prescriber course as soon as they have the relevant experience, rather than waiting for 2 years.
- 1.4 Course providers would still be required to assess the quality of the applicant's previous experience, to make sure that pharmacists have the necessary skills and experience before starting the course.

1.5 We received a total of **1,211** written responses to our consultation. **1,164** of these respondents identified themselves as individuals and **47** responded on behalf of an organisation.

## 2. Analysis of the consultation responses

2.1 An analysis of the responses is at Annex A and a summary of the main themes is set out below.

a) *proposal to remove the requirements for registered pharmacists to have two years of clinical practice before they can enrol on an accredited independent prescribing course.*

2.2 Just over half of all respondents (55%) agreed that the two-year requirement for entry to free-standing pharmacist independent prescribing training should be removed. However, agreement was much stronger amongst organisations than individuals. A large majority of organisations (81%) felt that we should remove the two-year requirement, whereas a slender majority of individuals (54%) gave the same response.

2.3 The main themes from those who supported the proposal were: that time served is not in itself the most effective determinant of relevant experience; that maintaining the two-year requirement would be unfair on existing registrants given the reforms to initial education and training which will enable those registering from 2025/26 to be independent prescribers at the point of registration; that this would increase the potential pool of prescribers to help alleviate pressure on health services and meet increased patient expectations; and that as experts in medicines, pharmacists generally had the necessary skills to prescribe sooner.

2.4 Those against the proposal highlighted that experience was required before being able to prescribe with the first few years in practice being important to develop knowledge and understanding of pharmacy; that experience in practice helps pharmacists gain confidence and allows them to settle into their role before taking on the added responsibility of prescribing; and that this would increase pressure on pharmacists at an early stage of their career. As a result of all these points, there was a potential impact on patient safety if the two-year requirement was removed.

2.5 Other comments highlighted the proposal for education providers to continue assessing relevant experience before enrolling individuals on independent prescribing courses. The importance of these assessments being applied consistently and the need for clarity on how these assessments would be made were essential in considering the proposal.

b) *proposal to remove the requirements for registered pharmacists to have relevant experience in a specific clinical or therapeutic area before they can enrol on an accredited independent prescribing course.*

2.6 Overall, a large majority of respondents (72%) agreed that we should remove the requirement to have relevant experience in a specific clinical or therapeutic area and replace it with the requirement to have relevant experience in appropriate clinical setting(s). The strength of agreement was marginally higher amongst organisations (77%) than individuals (72%).

2.7 The main themes highlighted in support of the proposal were that generalist skills are needed for prescribing; and that this would increase accessibility of independent prescribing training

and broaden opportunities for prescribing. Although there was a high level of support for this, many respondents also highlighted the need for greater clarity on terms such as 'appropriate clinical setting' to ensure that education providers were able to assess consistently.

*c) proposal to retain the requirement for course participants to identify an area of clinical or therapeutic practice as the basis of their learning and in which to develop their practice.*

- 2.8 A majority of all respondents (54%) agreed that we should retain the requirement that applicants must identify an area of clinical or therapeutic practice on which to base their learning. However, organisations and individuals differed in the extent to which they agreed with the proposal. A considerable majority of organisations (81%) agreed compared to a narrow majority of individuals (53%).
- 2.9 The main themes from those supporting the proposal were that identifying a specific area of practice would help focus learning. Similarly, respondents said that having a specific area of practice when training would be useful as a base for learning or starting point to build upon. Respondents also noted that a narrow scope of practice during training would enable pharmacists to develop the skills and principles of prescribing in depth for one area, which could then be applied to other areas. This was felt to be important for patient safety.
- 2.10 Those who disagreed with the proposal believed that, as generalist knowledge and skills are required for prescribing and that independent prescribers are not restricted to one area of practice once qualified, the training should reflect this. Similarly, some respondents pointed out that it would be beneficial or useful for independent prescribers to have a broad range of clinical skills and knowledge. The reasons given for these views included, although not exclusively, that prescribers have to deal with a wide range of conditions, including multi-morbidities and that generalist knowledge and skills would better support patient care.

### **3. Next steps**

- 3.1 We are now working through the important points highlighted in the consultation and will engage further with our Advisory Group for the initial education and training standards for pharmacists who have been closely involved in the development of thinking on this issue.

### **4. Equality and diversity implications**

- 4.1 Section 4 of the report at Annex A sets out responses on the impact of the changes based on protected characteristics. Overall, the majority of respondents believed there would be no particular impact or a positive impact based on the protected characteristics.

### **5. Communications**

- 5.1 The analysis report will be available publicly as part of the Council papers. We will also circulate to members of the Advisory Group.

### **6. Resource implications**

- 6.1 None arising at this stage.

### **7. Risk implications**

- 7.1 As part of the next steps we will be working through the risks identified by individuals and stakeholders prior to recommending an approach to Council.

## Monitoring and review

8.1 Once a policy approach has been agreed, we will set out how this will be monitored and reviewed, including through our accreditation methodology.

## Recommendations

Council is asked to:

- Note the analysis at **Appendix 1**
- Note the next steps

Mark Voce, Director of Education and Standards  
General Pharmaceutical Council

03/03/22

# **Revising the education and training requirements for pharmacist independent prescribers: analysis report**





# Contents

<b>Executive summary</b> .....	<b>1</b>
Background.....	1
Key issues raised in responses .....	1
<b>Introduction</b> .....	<b>4</b>
Policy background.....	4
<b>Analysis of consultation responses</b> .....	<b>6</b>
1. Removing the two-year time requirement .....	6
2. Changing the relevant experience requirement.....	10
3. Retaining the requirement to identify a specific area of clinical or therapeutic practice.....	14
4. The impact of the proposed changes.....	18
<b>Appendix 1: Summary of our proposals</b> .....	<b>25</b>
Part 1: Two-year time requirement.....	25
Part 2: Area of clinical or therapeutic practice .....	25
<b>Appendix 2: About the consultation</b> .....	<b>26</b>
Overview .....	26
Survey .....	26
<b>Appendix 3: Our approach to analysis and reporting</b> .....	<b>27</b>
Overview .....	27
Quantitative analysis .....	27
Qualitative analysis .....	28
The consultation survey structure.....	28
<b>Appendix 4: Respondent profile: who we heard from</b> .....	<b>29</b>
Category of respondents.....	29
Profile of individual respondents .....	29
Profile of organisational respondents .....	31
Monitoring questions .....	32

<b>Appendix 5: Organisations .....</b>	<b>33</b>
<b>Appendix 6: Consultation questions .....</b>	<b>35</b>
<b>Appendix 7: The impact of the proposed changes on people sharing particular protected characteristics .....</b>	<b>36</b>
Individual responses .....	36
Organisational responses.....	37
<b>Appendix 8: The impact of the proposed changes on other groups .....</b>	<b>38</b>
Individual responses .....	38
Organisational responses.....	38

# Executive summary

## Background

Between 28 September and 23 November 2021, we consulted on changes to requirements for training as a pharmacist independent prescriber, which will enable more pharmacists to become annotated as an independent prescriber. The changes include:

- removing the requirements for registered pharmacists to have two years of clinical practice before they can enrol on an accredited independent prescribing course
- removing the requirement for registered pharmacists to have relevant experience in a specific clinical or therapeutic area before they can enrol on an accredited independent prescribing course
- retaining the requirement that course participants must identify an area of clinical or therapeutic practice to focus on during the course

We delivered this consultation through a consultation survey, which received **1,211** responses: **1,164** from individuals and **47** on behalf of an organisation. 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. We also received **1** response from an organisation writing more generally about their views, bringing the total number of respondents up to **1,212**.

## Key issues raised in responses

### Views on removing the two-year time requirement

A slender majority of respondents (55%) agreed that the two-year requirement for entry to free-standing pharmacist independent prescribing training should be removed. Around two-fifths of all respondents (43%) disagreed with removing this requirement.

Respondents expressed mixed views in the explanatory comments on this proposal. Disagreeing with the change, many respondents thought that pharmacists need experience before being allowed to prescribe. Moreover, some respondents were concerned that patients would be put at risk by this proposal, while others were worried that pharmacists current education and training does not adequately equip them to become independent prescribers. On the other hand, some respondents held the view that pharmacists have the skills, knowledge and experience to prescribe before two-years served. Additionally, some respondents felt that it would be unfair on current pharmacists and trainees to retain the two-year requirement when newly qualified pharmacists will be accredited as independent prescribers at the point of registration and that this would create an unlevel playing field. It was also remarked by some respondents, in support of the proposal, that time served is not an accurate measure of competence.

### Views on changing the relevant experience requirement

The proposal to remove the requirement to have relevant experience in a specific clinical or therapeutic area and replace it with the requirement to have relevant experience in an appropriate clinical setting(s) received strong support from respondents. A considerable majority of respondents (72%) agreed with this change, while only 21% of respondents indicated that they were in opposition to it.

Of those who commented, many observed that generalist knowledge and skills are required for prescribing and, as such, experience in a specific area of practice should not be a requirement for entry onto independent prescriber training. Also in support of the proposal, many felt that changing the relevant experience requirement would improve accessibility to prescribing training, while some pointed out that the proposal would broaden applicants' opportunities once qualified. Moreover, some respondents were of the opinion that pharmacists already have the skills, knowledge and experience to prescribe, and therefore should not be required to gain experience in a specific area of practice before prescribing. In opposition to the change, many respondents thought that pharmacists need experience in a specialist clinical or therapeutic area before being allowed to train as a prescriber, particularly to ensure there is no risk to patient safety.

### **Views on retaining the requirement to identify a specific area of clinical or therapeutic practice**

Respondents views on retaining the requirement for applicants to independent prescribing courses to identify a specific area of clinical or therapeutic practice on which to base learning were fairly mixed. While a small majority of respondents (54%) indicated that they agreed with this proposal, just over a third of respondents (35%) in total felt that we should not retain the requirement.

In the comments, respondents views were also mixed. In support of the change, many respondents were of the opinion that the requirement to identify an area of practice is needed for learning. Similarly, many respondents felt that the requirement is important for patient safety, while some indicated that a specific area of clinical or therapeutic practice is needed to develop experts or specialists. In contrast, many respondents held the view that independent prescribing courses should focus on generalist skills and knowledge.

It was also suggested by some respondents that course providers should offer both generalist and specialist options. Moreover, some organisational respondents stressed the importance of independent prescribers practising within their competence.

### **Views on the impact of the proposals**

For most of the protected characteristics, the majority of respondents (ranging from 50% to 60%) felt that proposed changes would have no impact with the exception of age and pregnancy and maternity. Many respondents thought age (38%) and/or pregnancy and maternity (31%) would be positively impacted by the proposals. With respect to the rest of the protected characteristics, a moderate proportion of respondents (between 20% to 26%) felt that the impact would be positive.

With regard to other individuals and groups, many respondents (between 49% and 53%) felt that patients and the public, pharmacy owners/employers, pharmacy professionals and pharmacy student/pre-registration trainees would be positively impacted. In contrast, between 13% and 21% respondents viewed the impact as negative for these groups.

In the comments, many respondents shared the view that patients would benefit from the proposals, and many expressed that pharmacists would be positively impacted. Some respondents highlighted that employers and owners would benefit from the changes, while others made a similar observation with respect to the pharmacy profession as a whole. On the other hand, many respondents were worried that the changes would place patients at risk of harm. In addition, many respondents felt that students, pre-registration trainees and pharmacists would experience added pressure as a result of the proposals.

Respondents also frequently observed that the proposals would or could have a negative impact on age and currently registered pharmacists. Moreover, many individual respondents identified employers and pharmacy owners as a group that would or could be negatively impacted by the proposals.

# Introduction

## Policy background

Pharmacist independent prescribing was introduced in 2006, with pharmacists able to have their entry on our register ‘annotated’ to show they are an independent prescriber. Since then the number of pharmacist independent prescribers has increased. There are now 11,698 on the register, which is just under 20% of pharmacists registered with the GPhC.

When pharmacist independent prescribing was introduced, pharmacists who applied tended to be in their mid to late careers and wanted to train as specialists in a specific clinical or therapeutic area. In recent years, pharmacists starting independent prescriber training courses were more likely to want to develop a more generalist set of skills in response to changing patient needs. We see this as a natural evolution. Having a balance of specialist and generalist training simply reflects the breadth and diversity of the profession and is a response to the needs of the health service. When we discussed with student and trainee pharmacists what they expected their future practice to be like, it is clear that clinical practice, including independent prescribing, is what most of them expect.

Some parts of the health and care sector are seeing the benefits of pharmacists being prescribers, although independent prescribing is not yet widely adopted in all sectors of pharmacy. Also, annotation as being an independent prescriber is not a condition of (ongoing) registration and pharmacists may decide not to practise as an independent prescriber. While accepting that point, we expect independent prescribing to become more and more central to the practice of pharmacists as part of the natural evolution of the profession.

Given the rapid developments in pharmacy practice, including during the pandemic, we published revised standards for the initial education and training of pharmacists (IETP) in January 2021. These set out key reforms, including the introduction of independent prescribing knowledge and skills throughout the five years of initial education and training. This would lead to independent prescribing annotation at the point of registration.

The introduction of the 2021 IETP standards is a significant change. This means there needs to be a ‘transition’ period before the full set of learning outcomes, which include prescribing, can be implemented. Therefore, we have introduced an interim set of learning outcomes, for student and trainee pharmacists. These do not include the requirement for trainee pharmacists to both register and have the independent prescriber annotation at the same time. These have been introduced from the Foundation Training Year 2021/22 (which began in July 2021).

We expect the 2021 IETP standards to be implemented in full by 2025/26. The first full group of pharmacists with an independent prescriber annotation at the point of registration will therefore enter the register in the summer of 2026. Statutory education bodies and universities, working with employers and other stakeholders, are implementing this.

Given the rapid changes in pharmacy and the urgent need for more pharmacist independent prescribers, we do not think it is right simply to wait until 2025/26.

We have heard from key stakeholders about the need to make sure that people who are newly qualified, or are due to join the register in the next four years, are able to start working towards independent prescriber qualifications sooner. At the moment they need to have been registered for two

years. This is to make sure that the number of pharmacists beginning their careers without an independent prescriber qualification does not continue to grow and lead to a bottleneck in the present post registration courses.

We also want to take account of the fact that, during the transition period, we expect trainees to be building up prescribing skills year-on-year. As a result, we believe that removing the two-year requirement in the present prescribing standards would help achieve the overall aim. This would apply to pharmacists who are already registered and ones who have begun their initial education and training and will register before the summer of 2026.

Under this change, two routes to independent prescriber annotation would be available: as part of the initial education and training and through a free-standing training course. It would act on proposals from some statutory education bodies for independent prescribing training to be included in their post-registration foundation training programmes. This would lead to education being continued in the first two years after registration and therefore reduces the time before newly qualified pharmacists can enrol on an independent prescriber course.

For more detail on the changes we are proposing, see [Appendix 1: Summary of our proposals](#).

# Analysis of consultation responses

In this section of the report, the tables show the level of agreement/disagreement of survey respondents to our proposed changes. 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.

See [Appendix 2: About the consultation](#) for details of the consultation survey and the number of responses we received, [Appendix 3: Our approach to analysis and reporting](#) for full details of the methods used, [Appendix 4: Respondent profile](#) for a breakdown of who we heard from, and [Appendix 5: Organisations](#) for a list of organisations who responded. [Appendix 6: Consultation questions](#) contains a full list of the questions asked in the consultation survey.

## 1. Removing the two-year time requirement

**Table 1:** Views on removing the two-year time requirement for entry to free-standing pharmacist independent prescribing training (base: all respondents)

Q1. Should the two-year time requirement for entry to free-standing pharmacist independent prescribing training be removed?	N and % individuals	N and % organisations	N and % Total
<b>Yes</b>	623 (54%)	38 (81%)	661 (55%)
<b>No</b>	511 (44%)	7 (15%)	518 (43%)
<b>Don't know</b>	30 (3%)	2 (4%)	32 (3%)
<b>Total N and % of responses</b>	<b>1164 (100%)</b>	<b>47 (100%)</b>	<b>1211 (100%)</b>

Just over half of all respondents (55%) agreed that the two-year requirement for entry to free-standing pharmacist independent prescribing training should be removed. However, agreement was much stronger amongst organisational respondents than individuals. A large majority of organisations (81%) felt that we should remove the two-year requirement, whereas a slender majority of individuals (54%) gave the same response.

Approximately two-fifths of all respondents (43%) disagreed with removing the two-year requirement. When broken down further, table 1 shows a much higher proportion of individual respondents (44%) than organisations (15%) responded in this manner.

A very small percentage of respondents in total (3%) indicated that they did not know whether we should remove the two-year requirement.

The British Pharmaceutical Students' Association (BPSA) submitted a response to the consultation which has been counted as an organisational response. Their response included the findings of a survey of 185 students. These findings will be presented in this report alongside the overall survey findings. The



comments left by students, and collated and analysed by the BPSA, have been captured in our qualitative analysis.

In response to question 1, 84.3% of students surveyed by the BPSA agreed with our proposal to removal the two-year requirement for entry to an independent prescribing training programme.

Around three quarters of all respondents left explanatory comments to question 1. Set out below is an analysis of the themes found in their responses.

### **1.1. Summary of themes**

Respondents who left open-ended comments to this question held mixed views about the proposal. In opposition to the removing the two-year requirement, many respondents felt that pharmacists need experience before being allowed to prescribe. Additionally, some respondents were worried that removing the two-year requirement would present a risk to patient safety, while some raised concerns that the current education and training infrastructure is insufficient to accommodate this change. In contrast, some respondents thought that pharmacists have the skills, knowledge and experience to prescribe before two-years served. Moreover, those in support of the proposals felt that it would be unfair on current pharmacists and trainees to retain the two-year requirement when newly qualified pharmacists will be accredited as independent prescribers at the point of registration and that this would create an unlevel playing field. It was also remarked by some respondents that time served is not an accurate measure of competence.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- pharmacists need experience before being allowed to join independent prescribing training
- pharmacists have the skills, knowledge and experience to become prescribers before two years of practice
- removing two-year requirement presents risk to patient safety
- current MPharm and pre-registration training is insufficient
- retaining two-year requirement will create unfairness
- time served doesn't equal competence
- entry requirements for independent prescribing courses
- removing two-year requirement increases the supply of prescribers
- may create a potential shortage of DPPs and training places
- other comments

### **1.2. Pharmacists need experience before prescribing**

The most common theme to emerge from the responses was that pharmacists need experience before being allowed to prescribe. A much higher proportion of individual respondents made this point compared to organisations. According to these respondents, pharmacists are not ready to enrol on prescribing courses as soon as they qualify, and they should gain some experience in practice before being able to apply.

Some respondents felt that pharmacists need experience before taking on prescribing responsibilities in order to build up their competence, including developing the skills that would enable them to prescribe, such as communication and consultation skills. Similarly, some respondents stressed that the first few years in practice are important as they develop pharmacists' knowledge and understanding of pharmacy. It was also expressed that experience in practice helps pharmacists gain confidence and allows them to settle into their role before taking on the added responsibility of prescribing.

Respondents who shared these views were divided on how much experience pharmacists require before being allowed to join independent prescribing courses. For many of them, two years is a reasonable timeframe in which to gain the necessary experience. In contrast, some conceded that pharmacists may be able to obtain sufficient experience in less time, while a few felt that the two-year requirement should be extended.

### **1.3. Pharmacists have the skills, knowledge and experience to become prescribers before 2 years of practice**

Agreeing with the proposal, many respondents felt that pharmacists have sufficient skills, knowledge and experience to become prescribers before 2 years served as a registered pharmacist. The majority of these respondents drew attention to the 5-year qualifying education and training that prospective pharmacists undergo before registering, suggesting that this would adequately equip pharmacists to become prescribers. In addition, respondents highlighted that pharmacists are experts in medicine as evidence that they should be allowed to prescribe sooner. It was also observed that other healthcare professionals – such as doctors and nurses– are able to prescribe or join independent prescribing courses from day one of their registration, so pharmacists should be allowed to do the same.

### **1.4. Removing two-year requirement presents risk to patient safety**

Disagreeing with the proposal, many individual respondents expressed, either directly or indirectly, that allowing pharmacists with less than 2 years' experience to prescribe would put patients at risk of harm. In comparison, only a few organisational respondents raised this point. By leaving comments of this nature, these respondents clearly implied that junior pharmacists with only limited experience would be prone to making mistakes when prescribing and, in consequence, more likely to harm patients in the process.

### **1.5. Current MPharm and pre-registration training is insufficient**

Some respondents held the view that the current MPharm and pre-registration training year do not support removing the 2-year requirement as they do not adequately prepare pharmacists to prescribe before at least two years served. This was in direct opposition to the respondents who thought that the current education and training requirement would equip newly qualified pharmacists to become prescribers before gaining 2 years' experience (see section 1.3).

Of the respondents who commented in this manner, most said that newly qualified pharmacists lacked the experience, knowledge and skills to prescribe soon after qualifying. This opinion was sometimes based on the respondent's personal experience either as a junior pharmacist or working with newly qualified pharmacists. Respondents also specified that the current education and training requirements do not prepare pharmacists with enough clinical expertise to begin prescribing within two years of qualifying.

## **1.6. Retaining two-year requirement will create unfairness**

Some respondents observed that, in light of the introduction of the new Initial Education and Training for Pharmacists standards, it would be unfair on currently registered pharmacist and those due to register before 2026 to retain the two-year requirement. A higher proportion of organisational respondents than individuals left comments of this nature. By way of an explanation, these respondents highlighted that pharmacists qualifying in 2026 will become independent prescribers upon registration, and therefore it would only be fair to reduce the time needed for current pharmacists and trainees to become prescribers.

More specifically, respondents felt that if the two-year requirement was kept, current pharmacists and trainees would be at a disadvantage in terms of employability, pay and career progression. It was also suggested that a disparity in skill could be created between the two groups of pharmacists and that this could lead to a two-tier profession.

## **1.7. Times served doesn't equal competence**

In support of the proposal, some organisational respondents pointed out that time served as a qualified pharmacist does not necessarily equate to competence. In their opinion, having 2 or more years' experience in practice does not mean that a pharmacist will be ready to take on prescribing responsibilities. Some individual respondents also raised this point.

More specifically, respondents thought that it is more important to judge entry to independent prescribing courses on the quality of a pharmacists' experience and their competency, rather than time served. On the other hand, respondents suggested that newly qualified pharmacists develop at different rates; therefore, some will be ready to prescribe before others. For a few respondents, the 2 years seemed an arbitrary amount of time on which to base entry to an independent prescribing course.

## **1.8. Entry requirements for independent prescribing courses**

Many organisational respondents and a few individuals commented specifically on the requirement to demonstrate relevant experience, knowledge and skills for entry to independent prescribing courses. Generally agreeing with the proposal, some of these respondents stressed the importance of ensuring that applicants to independent prescribing courses are adequately assessed to make sure that they have the skills, knowledge and experience necessary to begin the qualification. Those respondents who tended to be against removing the two-year requirement were concerned that financial incentives would unduly influence course providers' assessments of suitability for prescribing courses, while others pointed towards potential inconsistency between course providers' entry requirements.

## **1.9. Increases supply of prescribers**

In support of the proposal, some organisational respondents and a few individuals drew attention to the benefits of increasing the number of prescribers in the UK. For example, respondents pointed out that it would reduce the pressure on the NHS and doctors for prescribing services. Additionally, respondents highlighted how it would improve access to treatment for patients. Moreover, respondents acknowledged that the demand for prescribers had increased significantly in recent years, suggesting or stating clearly that getting rid of the two-year requirement would help meet this demand. It was also noted that access to treatment for patients would improve under the proposal.

## 1.10. Potential shortage of DPPs and training places

Some organisational respondents were concerned that there may be a shortage of Designated Prescribing Practitioners (DPPs) and training places to accommodate the increased number of pharmacists wishing to train as independent prescribers that would result from the proposal. In contrast, this theme was found in the comments from only a few individual respondents.

## 1.11. Other themes

In addition to the themes outlined above, there were a number of other, less prevalent themes that emerged from the comments, the most common of which are captured below in order of prevalence. A number of these themes were found in responses to other questions and will therefore be explored in more detail later in the report.

- Some individual respondents felt that the proposal would put unnecessary pressure on pharmacists. For example, respondents pointed out that the first few years as a newly qualified pharmacist are challenging, and therefore adding prescribing responsibilities would create additional stress for them. In addition, respondents observed that newly qualified pharmacists may be pressured to prescribe outside their competence or when they otherwise do not feel comfortable to do so. It was also suggested that non-prescribing pharmacists may feel pressured to enrol on independent prescribing courses, particularly by employers.
- A few respondents expressed that the proposal would positively impact pharmacists. The reasons given by these respondents included that removing the requirement would allow them to progress their career sooner and give them more opportunities to upskill, amongst other reasons (see section 4.4).
- A few respondents thought that the two-year requirement could be removed only if the clinical content in the undergraduate degree, MPharm and pre-registration year is sufficient.
- According to a few respondents, the 2-year requirement should be reduced but not removed.
- In support of removing the two-year requirement, a few respondents highlighted that the proposal would increase accessibility to training for pharmacists.
- A few respondents thought that pharmacists should be allowed to utilise the knowledge and skills gained from the MPharm and pre-registration year immediately. Of these respondents, some felt that it would be detrimental for pharmacists to wait two years before being allowed to prescribe as they may lose some clinical knowledge and skills or motivation to become prescribers.
- Patients were singled out by a few respondents as a group that would benefit from removing the two-year requirement. The reasons given for this view included, although not exclusively, that it would reduce waiting times, provide better access to treatment and improve patient care (see section 4.2).

## 2. Changing the relevant experience requirement

**Table 2:** Views on changing the relevant experience requirement for entry to free-standing pharmacist independent prescribing training (base: all respondents)

<b>Q2. Should the requirement to have relevant experience in a specific clinical or therapeutic area be removed and replaced with the requirement to have relevant experience in appropriate clinical setting(s)?</b>	<b>N and % individuals</b>	<b>N and % organisations</b>	<b>N and % Total</b>
<b>Yes</b>	840 (72%)	36 (77%)	876 (72%)
<b>No</b>	249 (21%)	6 (13%)	255 (21%)
<b>Don't know</b>	75 (6%)	5 (11%)	80 (7%)
<b>Total N and % of responses</b>	<b>1,164(100%)</b>	<b>47 (100%)</b>	<b>1211 (100%)</b>

Overall, a large majority of respondents (72%) agreed that we should remove the requirement to have relevant experience in a specific clinical or therapeutic area and replace it with the requirement to have relevant experience in an appropriate clinical setting(s). The strength of agreement was marginally higher amongst organisational respondents (77%) than individuals (72%). In contrast, a modest proportion of all respondents (21%) thought that we should not change the relevant experience requirement. This view was more prevalent amongst individual respondents (21%) than organisations (13%).

A small percentage of respondents (7%) stated that they did not know whether we should change the relevant experience requirement. A higher percentage of organisational respondents (11%) did not know compared to individuals (6%).

In response to question 2, 69.7% of students surveyed by the BPSA agreed with our proposal to change the relevant experience requirement. Of the remainder, 22.2% were unsure or felt they did not have enough information to decide.

Just over half of all respondents left explanatory comments to question 2. Set out below is an analysis of the themes found in their responses.

## 2.1. Summary of themes

Respondents who commented on the proposal to replace the requirement to have relevant experience in a specific clinical or therapeutic area with the requirement to have relevant experience in an appropriate clinical setting(s) were largely in favour of this change. Of those in support, many were of the opinion that generalist knowledge and skills are required for prescribing, and therefore experience of a specific clinical and therapeutic area is not necessary before training to become a prescriber. In addition, many respondents were behind this change as it would increase pharmacists accessibility to independent prescribing courses. Along similar lines, some respondents highlighted how the proposal would broaden applicants' opportunities once qualified, while others thought that pharmacists already have the skills, knowledge and experience to prescribe, and therefore should not be required to gain experience in a specific area of practice before prescribing. In opposition to the proposed change, many respondents felt that pharmacists need experience in a specialist clinical or therapeutic area before being allowed to train as a prescriber, particularly to ensure there is no risk to patient safety.

The analysis that follows presents the themes that emerged from the comments, in order of prevalence, as listed here:

- generalist knowledge and skills are required for prescribing
- changing the experience requirement increases accessibility to prescribing
- pharmacists need experience before prescribing
- changing the experience requirement broadens opportunities for prescribers
- pharmacists need experience in a specialist clinical or therapeutic area before prescribing
- pharmacists have the skills, knowledge and experience to prescribe
- the proposal is too vague or further clarity is needed
- other themes

## **2.2. Generalist knowledge and skills are required for prescribing**

The most frequently raised point from the responses to this question was that generalist knowledge and skills are required for prescribing, which negates the necessity to have experience of a specific clinical or therapeutic area before embarking on a course. This type of comment was left by a higher proportion of organisations than individual respondents. The vast majority of these respondents made this point in support of changing the relevant experience entry requirement for independent prescribing training, although a few indicated that they were not in favour of this change.

Of the respondents who held this view, many highlighted that, once qualified, independent prescribers are able to prescribe in a wide range of clinical and therapeutic areas. Another prevalent observation by these respondents was that it would be beneficial or necessary to have more generalist prescribers, who have broader clinical knowledge and skills, in the workforce. Respondents also drew attention to the fact that most pharmacists, but particularly community and newly qualified pharmacists, are generalists, and therefore will need generalist knowledge and skills to prescribe.

## **2.3. Changing the experience requirement increases accessibility to training**

Agreeing with the proposal, many respondents held the opinion that removing the requirement to have relevant experience in a specific clinical or therapeutic area would increase accessibility to prescribing training for pharmacists. This theme was found in a much higher proportion of responses from organisations compared to those from individuals.

Many of these respondents stressed that it can be challenging to gain experience in a specific clinical or therapeutic area, thereby suggesting that the requirement acts as a barrier for some pharmacists. Along similar lines, respondents also stated that removing the requirement would allow more community pharmacists to enrol on independent prescribing courses. Newly qualified pharmacists were also singled out as a group that would have more access to prescribing training under the proposal.

## **2.4. Pharmacists need experience in a specific clinical or therapeutic area before training to prescribe**

In opposition to the proposal, many respondents felt that pharmacists need experience in a specific clinical or therapeutic area before being allowed to train as a prescriber. For example, some respondents held the view that gaining experience in a specific area of practice before training as an independent prescriber is important for patient safety. In addition, a few respondents noted that

trainee prescribers are required to identify a specific clinical or therapeutic area on which to base their learning, and therefore experience in this area is needed for the independent prescribing training.

## **2.5. Pharmacists need experience before prescribing**

Another common theme from the responses was the importance of gaining experience before prescribing (also see section 1.2 above), with some respondents highlighting the benefits of experience in more general terms. Those in support of changing the entry requirements went on to suggest or state explicitly that the experience should be relevant and in an appropriate clinical setting. However, some respondents went on to say that the experience must be in a specific clinical or therapeutic area (see section 2.4), thereby disagreeing with the planned change.

## **2.6. Changing the experience requirement broadens opportunities for prescribers**

In support of the proposal, some respondents pointed out that changing the experience requirement for entry onto independent prescribing courses would broaden opportunities for prescribers. For these respondents, this change would allow, or make it easier for, pharmacy professionals to go onto various roles and prescribe in a wide range of areas once qualified as an independent prescriber.

## **2.7. Pharmacists have the skills, knowledge and experience to prescribe**

In agreement with the proposal, some individual respondents highlighted that pharmacists already have the skills, knowledge and experience to prescribe, so they should not be required to gain experience in a specific area of practice before enrolling on an independent prescribing course. This type of comment was also left by a few organisational respondents.

More specifically, respondents observed that the education and training that pharmacists undergo before qualifying adequately equips them with the skills, knowledge and experience to prescribe. Additionally, respondents noted that doctors or other healthcare professionals are able to prescribe without gaining experience in specific area of practice. In doing so, they clearly implied that pharmacists should not have to do so either. It was also remarked that the knowledge, skills and experience to prescribe can be acquired during the training.

## **2.8. The proposal requires further clarity**

Many organisational respondents, in addition to a few individuals, indicated that the proposal was too vague or asked for further clarity to be provided. Most of these respondents felt that the term 'relevant experience' is too ambiguous or requires clarifying. Some of these respondents also queried how 'relevant experience' would be judged and were concerned that this may make it difficult for training providers to assess this at the point of entry to the training programme. It was also suggested that guidance should be issued to ensure the term is applied consistently. Similarly, 'appropriate clinical setting' was singled out by many of these respondents as an aspect of the proposal that needs to be defined, especially to ensure that it is applied consistently by course providers.

## **2.9. Other themes**

The following points were made by a small number of respondents each but still represented common themes from the responses.

- Some organisational respondents and a few individuals recognised the importance of applicants demonstrating sufficient levels of experience, knowledge and skills for entry onto independent prescribing courses.

- Some respondents stressed that pharmacists should prescribe within their area of competence. Many of these respondents expressed that independent prescribers should take responsibility to prescribe within their scope of competence. On a slightly different note, some said that independent prescribers should have the autonomy to prescribe when they feel comfortable to do so.
- A few respondents commented that there was not a ‘one size fits all’ approach and suggested experience in a specific area could be coupled with more general experience in an appropriate clinical setting. Similarly, they suggested course providers could offer both specialist and generalist training opportunities in order to meet the needs of pharmacists (see section 3.5).
- Agreeing with the proposal, a few respondents felt that retaining the requirement to have experience in a specific area of practice would act as a barrier to qualifying as an independent prescriber for some pharmacists, such as community pharmacist.
- In opposition to the planned change, a few respondents thought that experience in a specific area of practice should be retained in order to develop experts or specialist prescribers.

### 3. Retaining the requirement to identify a specific area of clinical or therapeutic practice

**Table 3:** Views on retaining the requirement to identify an area of clinical or therapeutic practice for entry to free-standing pharmacist independent prescribing training (base: all respondents)

Q3. Should we retain the requirement that applicants must identify an area of clinical or therapeutic practice on which to base their learning?	N and % individuals	N and % organisations	N and % Total
<b>Yes</b>	616 (53%)	38 (81%)	654 (54%)
<b>No</b>	422 (36%)	6 (13%)	428 (35%)
<b>Don't know</b>	126 (11%)	3 (6%)	129 (11%)
<b>Total N and % of responses</b>	<b>1164 (100%)</b>	<b>47 (100%)</b>	<b>1211 (100%)</b>

Table 3 shows that a narrow majority of all respondents (54%) agreed that we should retain the requirement that applicants must identify an area of clinical or therapeutic practice on which to base their learning. However, organisational respondents and individuals differed in the extent to which they agreed with the proposal. A considerable majority of organisations (81%) agreed compared to a narrow majority of individuals (53%).

Just over a third of respondents in total (35%) felt that we should not retain the requirement to identify a specific area of clinical or therapeutic practice. This opinion was much more common amongst individual respondents (36%) compared with organisations (13%).

Around a tenth of all respondents neither agreed nor disagreed with the proposal, although fewer organisations (6%) were unsure of the proposal than individuals (11%).



In response to question 3, 49.7% of students surveyed by the BPSA agreed with our proposal to retain the requirement to identify a specific area of clinical or therapeutic practice. The remainder were split equally between disagreeing with our proposal or being unsure.

Half of all respondents left explanatory comments to question 3. An analysis of the themes found in their responses is set out below.

### **3.1. Summary of themes**

There were three dominant themes to emerge from the responses to this question. Agreeing with the proposal, many respondents felt that the requirement to identify an area of practice is needed for learning. On a similar note, many respondents held the view that the requirement to identify an area of practice is necessary for patient safety. On the other hand, disagreeing with the proposal, many respondents thought that independent prescribing courses should focus on generalist skills and knowledge.

In addition to these themes, some respondents felt that course providers should offer both generalist and specialist options, while others held the view that a specific area of clinical or therapeutic practice is needed to develop experts or specialists. Moreover, some organisational respondents highlighted the importance of independent prescribers practising within their competence.

The themes found from the comments are explored below, in order of prevalence, as follows:

- a specific area of clinical or therapeutic practice is needed for learning
- prescribing courses should focus on generalist skills and knowledge
- a specific area of clinical or therapeutic practice is needed for safety
- training providers should offer both generalist and specialist options
- a specific area of clinical or therapeutic practice is needed to develop experts or specialists
- pharmacists should prescribe within their area of competence
- other themes

### **3.2. A specific area of clinical or therapeutic practice is needed for learning**

The most common theme to emerge for the comments on this question was that a specific area of clinical or therapeutic practice is needed for learning. For these respondents, the requirement to identify an area of practice before enrolling on an independent prescribing course is important for the applicant's learning and development whilst on the course. A higher proportion of organisational respondents left comments of this nature compared to individuals.

Many of these respondents observed that identifying a specific area of practice would help focus learning. Similarly, respondents said that having a specific area of practice when training would be useful as a base for learning or starting point from which to build upon. Respondents also noted that a narrow scope of practice during training would enable pharmacists to develop the skills and principles of prescribing in depth for one area, which can then be applied to other areas. On a slightly different note, respondents pointed out that independent prescribing courses are short, and therefore it makes sense to limit learning to one area of practice. It was also mentioned that a focus on one area makes it easier to complete the course.

### **3.3. Prescribing courses should focus on generalist skills and knowledge**

Many respondents held the view that independent prescribing courses should focus on generalist skills and knowledge. For the most part, these respondents disagreed with retaining the requirement for applicants to identify an area of practice on which to base their learning, although a few indicated that they agreed with this change or were unsure.

Some respondents thought that generalist knowledge and skills are required for prescribing, and therefore applicants should focus on generalist prescribing during their training. Similarly, some respondents pointed out that it would be beneficial or useful for independent prescribers to have a broad range of clinical skills and knowledge. The reasons given for these views included, although not exclusively, that prescribers have to deal with a wide range of conditions, including multi-morbidities, that generalist knowledge and skills would better support patient care and that independent prescribers are not restricted to one area of practice once qualified.

Some respondents were more direct, stating clearly that independent prescriber training should be generalist in nature, rather than specialist. According to these respondents, this would better reflect the practice of prescribers, support the desire to promote more generalist prescribing and optimise care for patients.

A few respondents observed that most pharmacists, but particularly community pharmacists and those working in GP practices, are generalist. In doing so, they implied that generalist skills and knowledge are necessary in order to treat patients, and therefore independent prescribing training should reflect this. Respondents also noted that a pharmacist's area of interest may change as their career progresses, so it would be unwise to specialise when training.

### **3.4. A specific area of clinical or therapeutic practice is needed for safety**

Another common theme from the responses was that the requirement to identify an area of clinical or therapeutic practice is needed to promote patient safety. Many respondents made this point, including a much higher proportion of organisational respondents than individuals. For these respondents, it would be unsafe to allow pharmacists to train as generalists, and therefore a specialism should be identified prior to entry.

More specifically, respondents felt that focusing on one area would allow applicants to become competent in that area, rather than spreading their knowledge and expertise too thinly. Additionally, respondents thought that in-depth knowledge of a clinical or therapeutic area is necessary to prescribe safely within that area. Similarly, respondents expressed that basing learning on one area would build applicants' confidence to prescribe. Respondents also argued that pharmacists should only prescribe within their competence, and that identifying a specific area of practice would encourage independent prescribers to practice within their competence.

### **3.5. Training providers should offer both generalist and specialist options**

Some respondents felt that training providers should offer both generalist and specialist options for independent prescribing courses in order to meet the needs of an increasingly wide range of prescribing roles. Many of these respondents suggested that applicants should be able to choose whether they focus on a specific area of practice or general prescribing. In their view, this would allow applicants to tailor the course to the needs of the practice area they would prescribe in once qualified. On a slightly different note, some of these respondents thought that independent prescribing training should include both generalist and specialist areas, in order to accommodate the diverse needs of patients.

Additionally, respondents noted that independent prescribers should be able to train as generalists first and then specialise later.

### **3.6. A specific area of clinical or therapeutic practice is needed to develop experts or specialists**

In support of the proposal, some individual respondents thought that applicants to independent prescribing courses should identify a specific area of clinical or therapeutic practice on which to base learning in order to develop experts or specialist prescribers. A few organisational respondents also made this point. According to these respondents, specialist prescribers or those with expertise in a specific area of practice, rather than generalist prescribers, are needed in the pharmacy workforce. Some of these respondents also mentioned that this would keep expertise diverse amongst the prescribing community, enabling pharmacists to better support patient care and treatment.

### **3.7. Pharmacists should prescribe within their area of competence**

Some organisational respondents highlighted the importance of independent prescribers practising within their competence. A few individual respondents also left comments of this nature. For example, respondents recommended that independent prescribing courses should teach pharmacist to identify and prescribe within their competence. These respondents tended to agree with the proposal. In contrast, generally disagreeing with the proposal, respondents felt that pharmacists should take responsibility to prescribe within their competence. Similarly, respondents expressed that independent prescribers should have the autonomy to prescribe when they feel competent to do so.

### **3.8. Other themes**

Alongside the themes already explored in this section, respondents raised a number of other points, which are captured below, in order of frequency.

- Generally disagreeing with the proposal, some respondents observed that identifying a specific area of practice for independent prescribing training would limit pharmacists to the roles they can undertake once qualified. A higher proportion of individual respondents left comments of this nature compared to organisations.
- For a few respondents, retaining the requirement to identify an area of clinical or therapeutic practice may limit the uptake on independent prescribing courses.
- A few respondents used this opportunity to highlight the importance of pharmacists gaining experience before prescribing (see sections 1.2 and 2.5).
- A few respondents felt that retaining the requirement to identify an area of clinical or therapeutic practice would positively impact the pharmacy profession (see section 4.10).
- Some organisational respondents and a few individuals thought that the proposal was too vague or further clarity was needed. For example, respondents suggested or stated explicitly that further clarity is needed with respect to the clause 'must identify an area of clinical or therapeutic practice on which to base their learning' and how it would be defined.
- A few respondents were of the opinion that independent prescriber training should focus on common clinical conditions or that this should be an option for applicants. Similarly, a few respondents remarked that training should include multiple area of practice.

- A few respondents observed that identifying an area of practice on which to focus learning would make it easier for training providers to assess an applicant’s competence.

## 4. The impact of the proposed changes

**Figure 1:** Views of all respondents (N = 1211) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

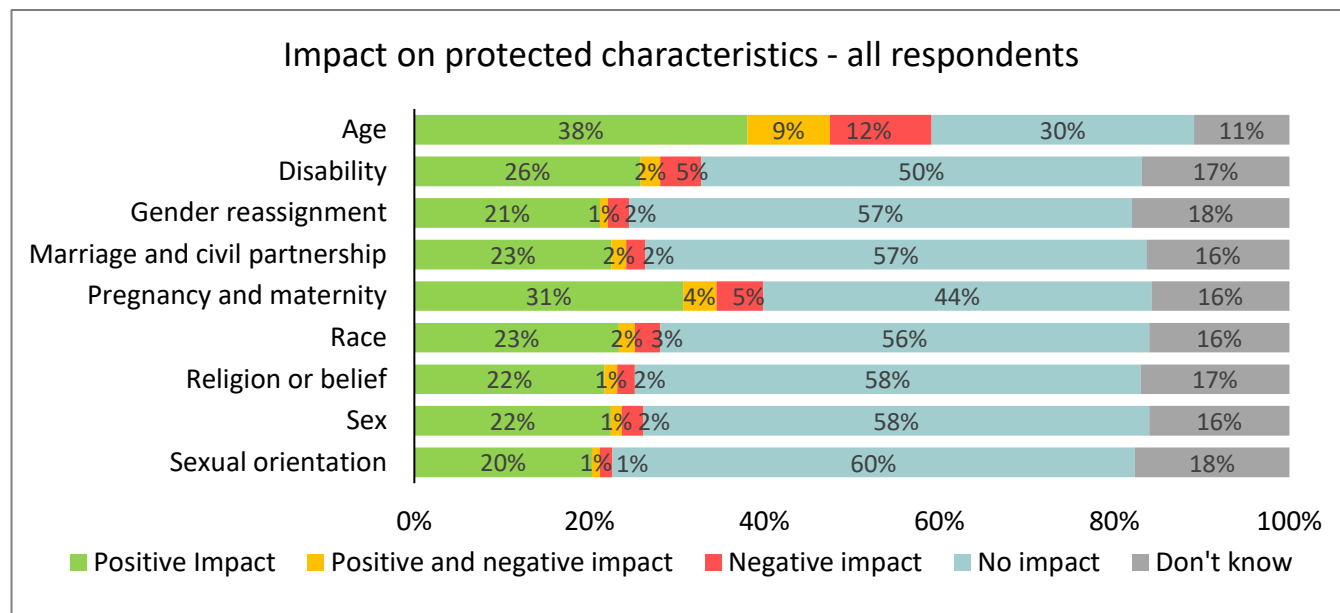


Figure 1 shows that, for seven of the nine protected characteristics, the majority of respondents (ranging from 50% to 60%) felt that the proposed changes would have no impact. The two exceptions to this were age and pregnancy and maternity where a smaller proportion of respondents selected ‘no impact’ (30% and 44% respectively).

Many respondents viewed age (38%) and/or pregnancy and maternity (31%) as protected characteristics that would be positively impacted by the proposals. For the rest of the protected characteristics, a moderate proportion of respondents (between 20% to 26%) thought that the impact would be positive.

Only a very small proportion of respondents (between 1% and 5%) felt that the proposals would have a negative impact on people sharing one or more of the nine protected characteristics, excluding age which 12% respondents thought would be negatively impacted. Similarly, a very small percentage of respondents (ranging from 1% to 4%) indicated that the proposals would have a positive and negative impact on all of the protected characteristics, with the exception of age (9%).

Across all the protected characteristics, a modest proportion of respondents (between 11% and 18%) did not know what the impact of the proposals would be.

A full breakdown of the views of individuals and organisations on the impact of the proposed changes on people sharing protected characteristics is available in [Appendix 7](#).

**Figure 2:** Views of all respondents (N = 1211) on whether our proposals positively or negatively impact any other individuals or groups

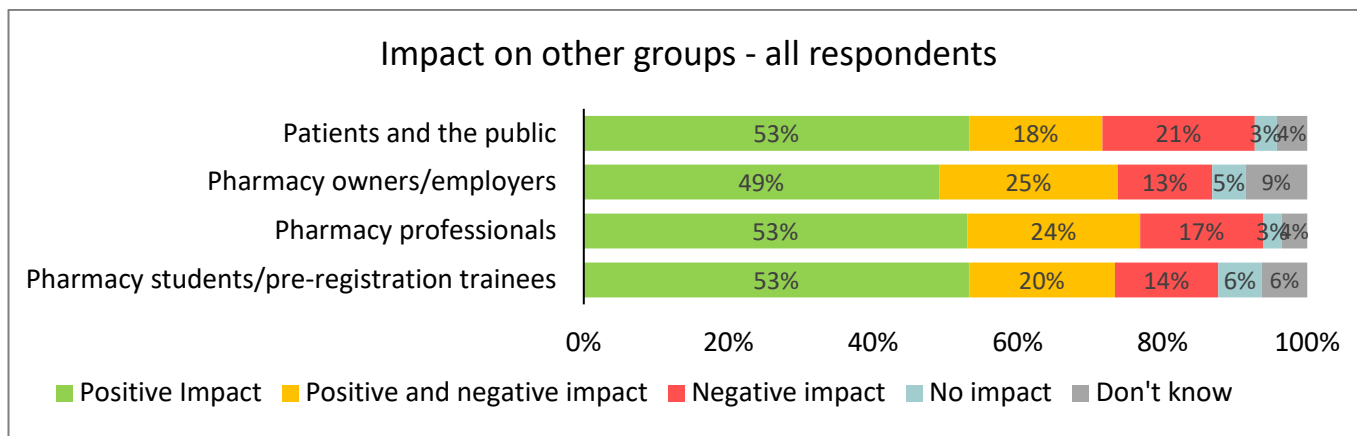


Figure 2 shows that many respondents thought that the proposed changes would have a positive impact on patients and the public (53%), pharmacy owners/employers (49%), pharmacy professionals (53%) and pharmacy student/pre-registration trainees (53%). Conversely, between 13% and 21% of respondents felt that these groups would be negatively impacted by the proposals.

A modest proportion of respondents (ranging from 18% to 25%) indicated that the proposed changes would have both a positive and negative impact on the groups identified above, while only a small percentage felt that the proposals would have no impact on people sharing certain protected characteristics or did not know what the impact would be.

A full breakdown of individual and organisational responses on the impact of the proposed changes on other groups is available in [Appendix 8](#).

Just over half of all respondents left explanatory comments on the impact of the proposals. Set out below is an analysis of the themes found in their responses.

#### 4.1. Summary of themes

Respondents shared mixed views in the comments to the impact questions. In support of the proposals, many respondents expressed that patients would be positively impacted by the changes. Similarly, a large number of respondents recognised the benefits that the proposals would have on pharmacists. Some respondents highlighted that employers and owners would be positively impacted, while a similar proportion made the same point with regard to the pharmacy profession as a whole. On the other hand, many respondents were concerned that the proposals would put patients at risk of harm. Equally, many respondents felt that students, pre-registration trainees and pharmacists would experience added pressure as a result of the changes. It was also noted by many individual respondents that the proposals would or could have a negative impact on age and currently registered pharmacists. Similarly, many individual respondents identified employers and pharmacy owners in their comments as a group that would or could be negatively impacted by the proposals.

Set out below are the themes found in the responses to the impact questions, in order of prevalence, as listed here:

- benefits patients
- risk to patient safety
- benefits pharmacists
- pressure on students, pre-registrants and pharmacists

- negative impact on age
- cost for employers and pharmacy owners
- benefits employers and pharmacy owners
- pharmacists need experience before prescribing
- benefits the pharmacy profession
- undermines the pharmacy profession
- increases the supply of prescribers
- benefits women and primary care givers
- potential shortage of DPPs or training places
- increases accessibility to training
- retaining two-year requirement will create unfairness
- other themes

## 4.2. Benefits patients

The most prevalent theme from the comments on the impact questions was that patients would benefit from the proposals. This point was made by many respondents, including a higher proportion of organisational respondents than individuals. For most of these respondents, the planned changes would improve patient access to prescribing services and medicines by increasing the number of prescribers available, shortening waiting times and removing the need to get an appointment with the GP. Similarly, some of these respondents noted that the proposals would enhance the level of care provided to patients by upskilling the pharmacy workforce.

## 4.3. Risk to patient safety

Many respondents were concerned that the proposals would or could have a negative impact on patients by placing them at risk of harm. A higher proportion of individual respondents than organisations left comments of this nature. This theme was also common in the responses to question 1 (see section 1.4).

Where provided, respondents gave a wide range of explanations for this viewpoint. Many of these respondents stressed that the public would be put at risk from an increase in inexperienced prescribers in the workforce. In doing so, they suggested that inexperienced pharmacists are more likely to make errors when prescribing. Some respondents argued that newly qualified pharmacist do not have the skills, knowledge or experience to prescribe safely. Other explanations given included, that employers may pressure inexperienced pharmacists to prescribe outside their competence, that newly qualified pharmacists may not have the experience to prescribe for vulnerable groups or those sharing a particular protected characteristic and that prescribers may be tempted to prescribe outside of their competence.

## 4.4. Benefits pharmacists

Another common theme from the comments on the impact of the proposals was that pharmacists would benefit from the changes. Of the respondents who held this opinion, many made general remarks that pharmacists as a whole would benefit from the proposals. The reasons given for such remarks

included, although not exclusively, that the changes would help pharmacists progress their career, develop additional knowledge and skills, improve their employability and increase their job satisfaction. On the other hand, many of these respondents were more specific, singling out younger or newly qualified pharmacists as a group that would be positively impacted given they would be able to extend the scope of their practice sooner and the 2-year barrier to prescribing would be removed, amongst other reasons. Mature students or late starting pharmacists were also highlighted as a group that would benefit from the proposals, especially as they would not have to wait two years to take on prescribing responsibilities.

#### **4.5. Pressure on students, pre-registrants and pharmacists**

Many respondents felt that the proposals would put pressure on pharmacy students, pre-registration pharmacists and qualified pharmacists. For example, respondents expressed that newly qualified pharmacists may be pressured into becoming independent prescribers before they are ready. Similarly, respondents observed that older pharmacists or those that have been qualified for a while may feel pressured to enrol on an independent prescribing course. On a slightly different note, respondents suggested that some pharmacists, particular those that are newly qualified or have only limited experience, may receive pressure – from, for example, employers – to prescribe outside their competence or when they otherwise do not feel comfortable to do so. It was also noted that the proposals would put more pressure on students and pre-registrants by adding prescribing training to their workload.

#### **4.6. Negative impact on age and current registrants**

Many individual respondents thought that the proposals would have a negative impact on age and current registrants. This type of response was also left by a few organisational respondents. For example, respondents highlighted that the proposals would create an unlevel playing field for older or currently registered pharmacists in terms of employment compared to their younger counterparts, particularly if many of the former are not qualified as prescribers but the latter are. Similarly, respondents pointed out that older or currently registered pharmacists may find it more challenging to access independent prescribing training than younger pharmacists. It was also noted that more experienced pharmacists would be deskilled by the proposals or become second-class professionals.

#### **4.7. Cost for employers and pharmacy owners**

Many respondents identified employers and pharmacy owners in their comments as a group that would or could be negatively impacted by the proposals. A much higher proportion of organisations left comments of this nature compared to individual respondents.

Most of the respondents who shared this view pointed to the burden that would be placed on employers and owners to support pharmacists to become independent prescribers. For example, respondents highlighted the cost of employing staff to cover a pharmacist taking time off to study for the prescribing qualification and of putting additional resources in place to facilitate prescribing training, including Designated Prescribing Practitioners. Additionally, respondents noted that the proposals could create staffing issues for pharmacies, such as a shortfall of locums and a shortage of non-prescribing pharmacists, amongst others. It was also observed that employers and owners would have to bear the extra cost of an increase in independent prescribers in the workforce.

#### **4.8. Benefits employers and pharmacy owners**

In opposition to the respondents who said that the proposals would have a negative impact on employers (see section 4.7), some respondents expressed that the proposals would have a positive impact on employers and pharmacy owners. Many of these respondents suggested that the changes would help pharmacies provide a better service to patients and members of the public. On a similar note, many of them observed that the proposals would result in more qualified and skilled pharmacy staff. Respondents also argued that employers and owners would benefit financially from the proposals. By way of an explanation, respondents said the proposals would improve access to prescribers for employers, increase the range of services they could provide and drive down the price of prescribers. Additionally, it was noted that employers would benefit from a larger pool of prescribers to choose from when recruiting.

#### **4.9. Pharmacists need experience before prescribing**

Some individual respondents used this opportunity to stress the importance of pharmacists gaining experience in practice before being allowed to prescribe. This theme was commonly found in the responses to questions 1 and 2, and therefore has been explored in more detail above (see sections 1.2 and 2.5).

#### **4.10. Benefits the pharmacy profession**

Some respondents held the view that the proposals would benefit the pharmacy profession. Many of these respondents remarked in general terms that the pharmacy profession would be positively impacted by the planned changes. Others observed that the proposals would upskill the workforce as a whole. Respondents also argued that the proposals would raise the profile of the profession and improve its reputation. It was also noted that the changes would allow pharmacists to make a greater contribution to patient care.

#### **4.11. Undermines the pharmacy profession**

For some individual respondents, in addition to a few organisations, the planned changes would undermine public confidence in the pharmacy profession. This was in direct opposition to the respondents who felt that the proposals would have a positive impact on the reputation of the profession (see section 4.10).

By way of an explanation, many of these respondents pointed out that the proposals would increase the number of inexperienced prescribers in the workforce. Similarly, some of these respondents justified their viewpoint by stating that the proposals would lead to more prescribing errors. It was also observed that the proposals would lower the standard of prescribing amongst the profession as a whole.

#### **4.12. Increases supply of prescribers**

Some individual respondents and a few organisations felt that the proposals would have a positive impact by increasing the supply of prescribers in the NHS. Many of these respondents expressed that the changes would reduce the pressure on the NHS, GPs and other current prescribers. On a slightly different note, some of them pointed out that the proposals would help meet the increasing demand for prescribing services. It was also noted that the proposals would create more Designated Prescribing Practitioners to train future independent prescribers.



#### **4.13. Benefits women and primary care givers**

Some organisational respondents thought that women and primary care givers would be positively impacted by the proposals. A few individual respondents also shared this view. For example, respondents pointed out that the changes would allow more flexibility for those planning their career around having children. Some of the respondents who raised this point went on to observe that women often put off pregnancy until after they are qualified as an independent prescriber. In addition, respondents said that under the proposals taking time off to have children would have less of an impact on someone becoming a prescriber, especially given the proposed removal of the 2-year experience requirement for entry onto a prescribing course.

#### **4.14. Potential shortage of DPPs or training places**

Some organisational respondents raised concerns that the resources needed to train independent prescribers may be stretched thin by the proposals. For these respondents, the increased demand for prescribing courses that would result from the planned changes may lead to a shortage of Designated Prescribing Practitioners to train independent prescribers and training places themselves. A few individual respondents also shared this view.

#### **4.15. Increases accessibility to training**

Some organisations, in addition to a few individual respondents, pointed out that the proposals would give more access to independent prescriber training for pharmacy professionals, especially newly qualified pharmacists and those working in a community setting. In particular, the proposals to remove the two-year requirement and to change the relevant experience requirement for entry onto an independent prescribing course were singled out as changes that would increase accessibility to prescribing training for pharmacists.

#### **4.16. Retaining 2-year requirement will create unfairness**

In a similar fashion to the responses provided for question 1 (see section 1.6), some organisational respondents and a few individuals observed that retaining the 2-year requirement would create unfairness for current qualified pharmacists or those due to join the register before 2026. In their view, if pharmacists qualifying in 2026 will be accredited as independent prescribers at the point of registration, it would be unfair on those currently registered or undertaking their training to wait 2-years before being allowed to enrol on a prescribing course.

#### **4.17. Other themes**

Respondents raised several other points on the impact of the proposals in addition to those already explored. A selection of these points are highlighted below, in order of prevalence.

- A few respondents left comments expressing that the proposals would have no impact on any of the individuals or groups who share certain protected characteristics.
- A few respondents thought that the proposals would have a negative impact on community pharmacy. For example, respondents observed that pharmacists may be tempted to leave community pharmacy in order to seek prescribing roles in GP surgeries of hospitals.
- A few respondents stressed that the independent prescribing course should be accessible and affordable. Respondents felt that there should be flexible learning options for the training, such as distance learning and the option to continue working while studying. Respondents also

argued that funding should be available for pharmacists to undertake the course and that pharmacies should receive extra funding to support pharmacists to complete prescribing training.

- A few respondents felt that women, pharmacists working part time and individuals with disabilities would or could be negatively impacted by the proposals. According to these respondents, these groups, who are more likely to work part time or take career breaks (for example, to have children), would find it more challenging to access the course and to complete the training itself. They also felt that the proposals could negatively impact their employability, particularly with respect to women who have not qualified as a prescriber before starting a family.
- A few individual respondents suggested that employers may exploit the planned changes with regard to pay, resourcing or progression.
- A few respondents were worried that the proposals would take focus away from other important areas of pharmacy with regard to training and practice.
- A few individual respondents cautioned that the proposals may lead to increased fitness to practise concerns being raised or more legal action taken against pharmacists.

# Appendix 1: Summary of our proposals

## Part 1: Two-year time requirement

**We propose to remove the requirement for registrants to complete two years in practice before becoming eligible to enrol on to an accredited independent prescribing course.**

We want to enable currently registered and newly qualified pharmacists joining the register over the next few years to be able to begin their independent prescriber course as soon as they have acquired the relevant experience, rather than having to wait two years.

Course providers would still be required to assess the quality of the applicant's previous experience, to make sure that pharmacists have the necessary skills and experience before starting the course.

By removing the two-year time requirement, we believe this will result in all routes to becoming an independent prescriber being built on a stronger clinical base and which does not rely on time served as a measure of quality.

## Part 2: Area of clinical or therapeutic practice

**We propose to change the wording in the entry requirements in relation to the experience for entry to a free-standing independent prescribing course and separate it into two distinct points:**

- a. Applicants must have relevant experience in a pharmacy setting and be able to recognise, understand and articulate the skills and attributes required by a prescriber to act as the foundation of their prescribing practice whilst training.**
- b. For the purposes of developing their independent prescribing practice applicants must identify an area of clinical or therapeutic practice on which to base their learning.**

This will enable those with limited experience in relation to one area of clinical specialty to enrol onto the free-standing independent prescribing courses as well as support the desire of many of the key pharmacy stakeholders to promote generalist prescribing as a starting point.

The course providers will still require their students to identify an area of clinical or therapeutic practice, but this could include common clinical conditions for example. The skills and attributes of a prescriber will be covered in the course and the purpose of the defined clinical or therapeutic practice area is to allow the student to focus their learning but does not mean they are restricted to that area of practice upon qualification.

More detail about our proposals is available in the [consultation document](#).

# Appendix 2: About the consultation

## Overview

The consultation was open for 12 weeks, beginning on 28 September 2021 and ending on 23 November 2021. 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 created a toolkit of materials for organisations to disseminate information about the consultation to their members, including pre-written newsletter and social media content and presentation slides
- we promoted the consultation through direct emails to stakeholders, press release to the pharmacy trade media and via our social media.

## Survey

We received a total of **1,212** written responses to our consultation. **1164** of these respondents identified themselves as individuals and **48** responded on behalf of an organisation.

Of these responses, **1,211** 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 **1** responses an organisation writing more generally about their views.

# Appendix 3: Our approach to analysis and reporting

## Overview

Every response received during the consultation period 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.

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. It includes both individuals and organisations.

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 and/or email responses. A small number of organisations asked for their participation to be kept confidential and their names have been withheld.

The consultation questions are provided in [Appendix 6](#).

## Quantitative analysis

The survey contained a number of quantitative questions such as yes/no questions. All responses have been collated and analysed including those submitted by email or post using the consultation document. Those responding by post or email more generally about their views are captured under the qualitative analysis only.

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

A small number (less than 10) of multiple responses were received from the same individuals. These were identified by matching on email address and name. In these cases, the individual respondent’s most recent response was included in the quantitative analysis, and all qualitative responses were analysed.

The tables contained within this analysis report present the number of respondents selecting different answers in response to questions in the survey. The ordering of 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%. Figures of less than 1% are represented as <1%.

All questions were mandatory and respondents had the option of selecting 'don't know'. Routing was used where appropriate to enable respondents to skip questions that weren't relevant. Skipped responses are not included in the tables for those questions.

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.

The qualitative nature of the responses here meant that we were presented with a variety of views, and rationales for those views. Responses were carefully considered throughout the analysis process.

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

Prevalence of views was identified through detailed coding of written responses and analysis of feedback from stakeholder events using the themes from the coding framework. The frequency with which views were expressed by respondents is indicated in this report with themes within each section presented in order of prevalence. The use of terms also indicates the frequency of views, for example '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

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

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

# Appendix 4: Respondent profile: who we heard from

A series of introductory questions sought information on individuals' general location, and in what capacity they were responding to the survey. Further questions were asked of pharmacy professionals and trainees to identify the setting in which they usually worked and pharmacists were asked about their prescribing status. For organisational respondents, there were questions about the type of organisation that they worked for. The tables below present the breakdown of their responses.

## Category of respondents

**Table 4:** Responding as an individual or on behalf of an organisation (base: all respondents)

Are you responding:	Total N	Total %
As an individual	1164	96%
On behalf of an organisation	47	4%
<b>Total N and % of responses</b>	<b>1211</b>	<b>100%</b>

## Profile of individual respondents

**Table 5:** Countries (base: all individuals)

Where do you live:	Total N	Total %
England	988	85%
Scotland	118	10%
Wales	44	4%
Northern Ireland	1	<1%
Other	13	1%
<b>Total N and % of responses</b>	<b>1164</b>	<b>100%</b>

**Table 6:** Respondent type (base: all individuals)

Are you responding as:	Total N	Total %
A pharmacist	916	79%
A pre-registration/foundation trainee pharmacist	137	12%
A pharmacy student	73	6%
A member of the public	14	1%
A pharmacy technician	9	1%
A pre-registration trainee pharmacy technician	1	<1%

Are you responding as:	Total N	Total %
Other	14	1%
<b>Total N and % of responses</b>	<b>1164</b>	<b>100%</b>

**Table 7:** Annotation type (base: all pharmacists)

Are you annotated as:	Total N	Total %
I am a pharmacist but not a prescriber	568	62%
An independent prescriber	297	32%
Both a supplementary and independent prescriber	43	5%
A supplementary prescriber	8	1%
<b>Total N and % of responses</b>	<b>916</b>	<b>100%</b>

**Table 8:** Main area of work (base: individuals excluding members of the public and 'other' respondents)

Please choose the option below which best describes the area you mainly work in:	Total N	Total %
Hospital pharmacy	415	36%
Community pharmacy (including online)	395	35%
GP practice	161	14%
Primary care organisation	48	4%
An institution delivering an independent prescribing course	19	2%
Research, education or training (but not offering an independent prescribing course)	18	2%
Pharmaceutical industry	8	1%
Care home	4	<1%
Prison pharmacy	1	<1%
Other	67	6%
<b>Total N and % of responses</b>	<b>1136</b>	<b>100%</b>

**Table 9:** Type of community pharmacy (base: individuals working in community pharmacy)

Which of the following best describes the community pharmacy you work in (or own):	Total N	Total %
Independent pharmacy (1 pharmacy)	52	13%
Independent pharmacy chain (2-5 pharmacies)	61	15%
Small multiple pharmacy chain (6-25 pharmacies)	38	10%



Which of the following best describes the community pharmacy you work in (or own):	Total N	Total %
Medium multiple pharmacy chain (26-100 pharmacies)	30	8%
Large multiple pharmacy chain (Over 100 pharmacies)	194	49%
Online-only pharmacy	2	1%
Other	19	5%
<b>Total N and % of responses</b>	<b>396</b>	<b>100%</b>

## Profile of organisational respondents

**Table 10:** Type of organisation (base: all organisations)

Please choose the option below which best describes your organisation	Total N	Total %
An institution delivering an independent prescribing course	13	28%
NHS organisation or group	10	21%
Organisation representing pharmacy professionals or the pharmacy sector	9	19%
Research, education or training organisation (but not offering an independent prescribing course)	5	11%
Registered pharmacy	3	6%
Government department or organisation	1	2%
Organisation representing patients or the public	1	2%
Regulatory body	1	2%
Other	4	9%
<b>Total N and % of responses</b>	<b>47</b>	<b>100%</b>

**Table 11:** Type of community pharmacy (base: organisations working in community pharmacy)

Which of the following best describes the community pharmacy you work in (or own):	Total N	Total %
Independent pharmacy chain (2-5 pharmacies)	1	33%
Large multiple pharmacy chain (over 100 pharmacies)	2	67%
<b>Total N and % of responses</b>	<b>3</b>	<b>100%</b>

## 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 (NB. a further two organisations requested for their names and responses to be kept confidential):

- Bangor University
- Boots Pharmacists Association
- Boots UK
- British Pharmaceutical Students' Association (BPSA)
- Centre for Pharmacy Postgraduate Education
- Community Pharmacy Scotland
- Community Pharmacy Wales
- De Montfort University
- Division of Pharmacy and Optometry, The University of Manchester
- Guild of Healthcare Pharmacists
- Hampshire Hospitals NHS Foundation Trust
- Health Education and Improvement Wales
- Health Education England
- Healthcare Improvement Scotland
- Mid Yorkshire Hospitals NHS Trust
- N.S Wilson Ltd
- National Pharmacy Association
- Newcastle Upon Tyne Hospitals
- NHS Education for Scotland
- NHS Lothian
- NHS Wales, Swansea Bay University Health Board
- NICPLD, Queen's University Belfast
- North West Non-Medical Prescribing Education Group
- Nursing and Midwifery Council (NMC)
- Office of the Chief Pharmaceutical Officer, NHS England
- Pharmaceutical Services Negotiating Committee
- Pharmacist Support
- Primary Care

- ProPharmace Ltd
- Response on behalf of Directors of Pharmacy (Scotland)
- Robert Gordon University
- Rowlands Pharmacy
- Royal Pharmaceutical Society (RPS)
- School of Pharmacy, Queen's University Belfast
- Surrey LPC
- Swansea University
- The CCA
- The Pharmacists' Defence Association (PDA)
- Turning Point
- UCL School of Pharmacy
- University of Bradford School of Pharmacy & Medical Sciences
- University of Huddersfield
- University of Leeds
- University of Salford
- University of Strathclyde
- University of York

## Appendix 6: Consultation questions

1. Should the two-year time requirement for entry to free-standing pharmacist independent prescribing training be removed?

Please explain your answer

2. Should the requirement to have relevant experience in a specific clinical or therapeutic area be removed and replaced with the requirement to have relevant experience in appropriate clinical setting(s)?

Please explain your answer

3. Should we retain the requirement that applicants must identify an area of clinical or therapeutic practice on which to base their learning?

Please explain your answer

We want to understand whether our proposals may have a positive or negative impact on any individuals or groups sharing any of the protected characteristics in the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and Civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

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

We also want to know if our proposals will have an impact on other individuals or groups (not related to protected characteristics) – specifically, patients and the public, pharmacy owners and employers, pharmacy professionals, and pharmacy students and pre-registration trainees.

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

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

# Appendix 7: The impact of the proposed changes on people sharing particular protected characteristics

## Individual responses

**Figure 3:** Views of individual respondents (N = 1164) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

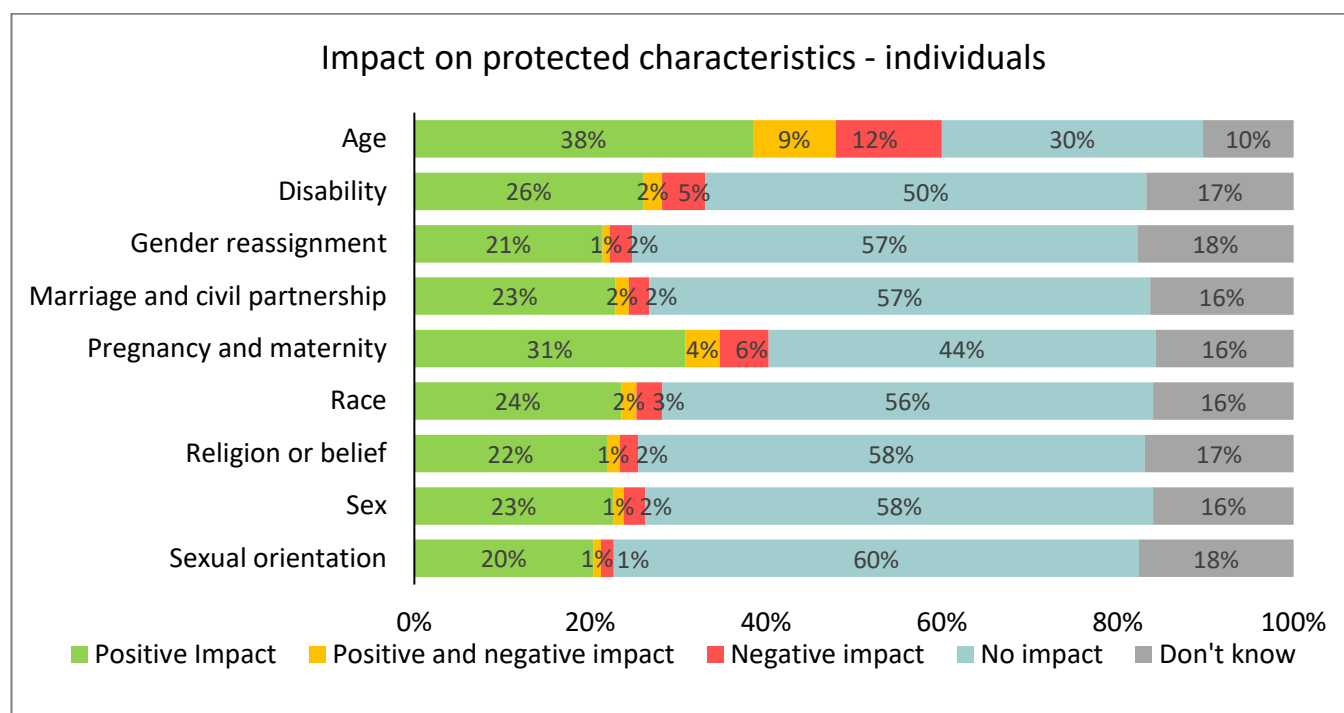


Figure 3 shows that most individual respondents (between 50% and 60%) thought that the proposals would have no impact on people sharing particular protected characteristics, except for age (30%) and pregnancy and maternity (44%).

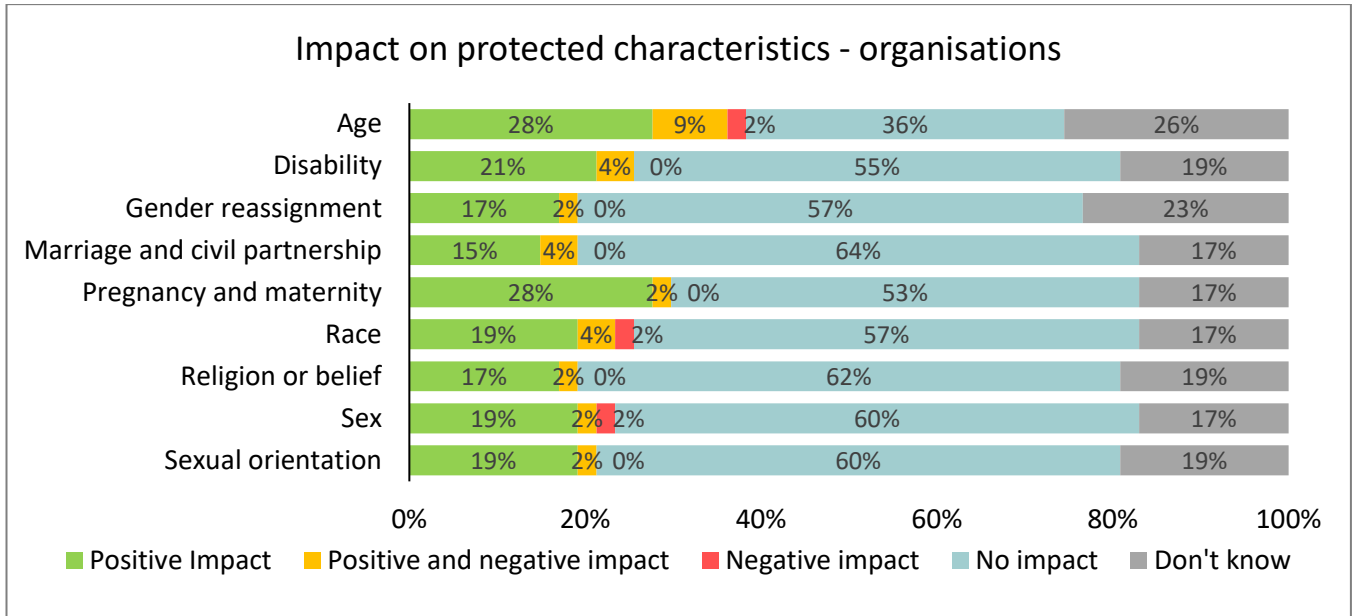
Between 20% and 38% of individual respondents indicated that the proposals would have a positive impact on the groups listed above. In contrast, only a very small percentage of individual respondents (ranging from 1% to 6%) viewed the proposals as having a negative impact on those who share particular protected characteristics, with the exception of age which received a slightly higher percentage (12%).

A small proportion of individuals thought the proposals would have both a positive and negative impact on the groups listed above (1% to 9%).

Please see section 4 in the main body of the report for the chart showing the overall responses and further analysis.

## Organisational responses

**Figure 4:** Views of organisations (N = 47) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010



Most organisational respondents (ranging from 53% to 64%) thought that the proposals would have no impact on the groups shown above, with the exception of age which just over a third of organisations (36%) felt would not be impacted.

Between 15% and 28% of organisational respondents indicated that the proposals would have a positive impact on those sharing certain protected characteristics. In contrast, between 2% and 9% felt that the above groups would be positively and negatively impacted.

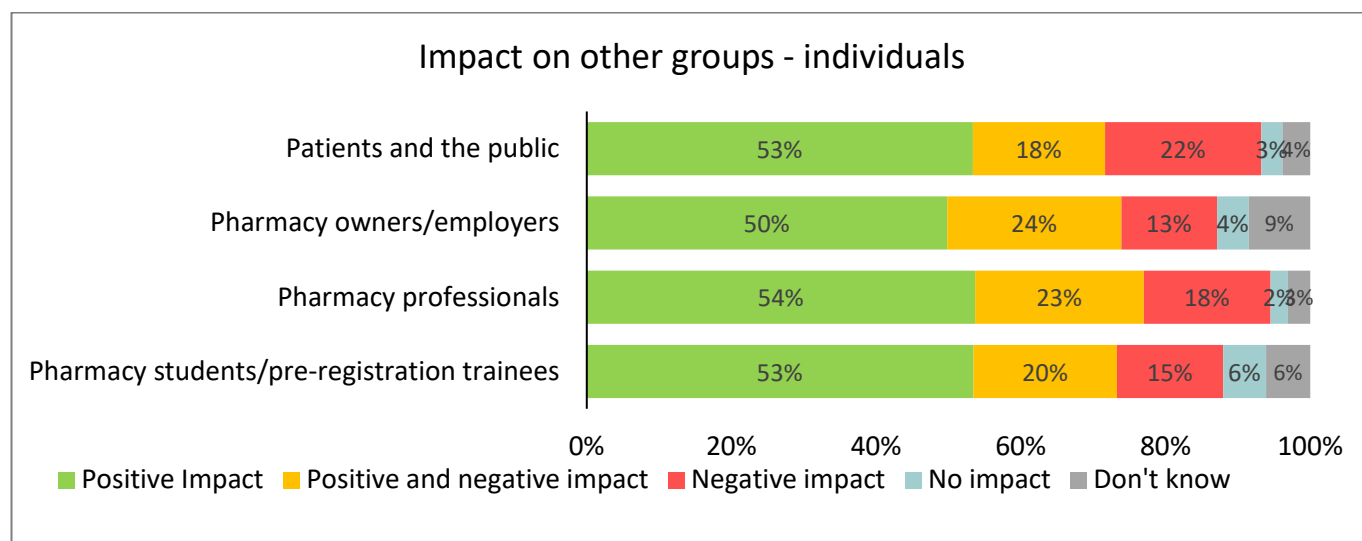
Age, race and sex were identified as protected characteristics that would be negatively impacted, but only by a very small proportion of organisational respondents (2% each).

Please see section 4 in the main body of the report for the chart showing the overall responses and further analysis.

# Appendix 8: The impact of the proposed changes on other groups

## Individual responses

**Figure 5:** Views of individual respondents (N = 1164) on whether our proposals positively or negatively impact other individuals or groups



The majority of individual respondents (ranging from 50% to 54%) indicated that the groups listed above would be positively impacted by the proposed changes. In contrast, a modest percentage of individuals (between 13% and 22%) felt that the other groups would be negatively impacted. Similarly, a moderate proportion of individuals (ranging from 18% to 24%) viewed the proposals as both positive and negative for these groups.

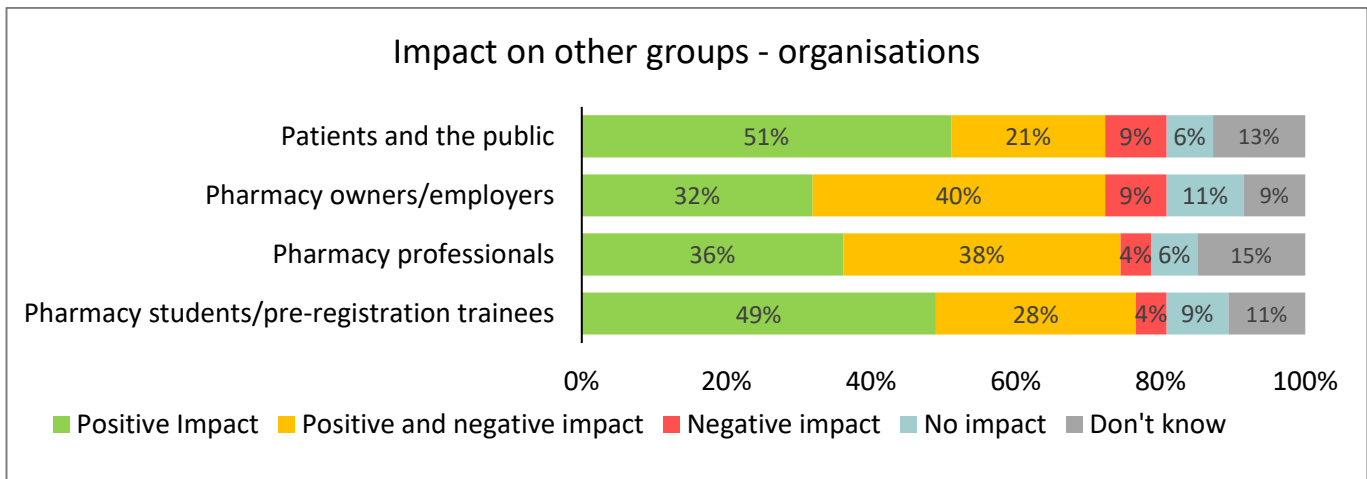
A small number of individuals either did not know what the impact of the proposals would be or felt that they would have no impact on the groups listed above.

Please see section 4 in the main body of the report for the chart showing the overall responses and further analysis.

## Organisational responses

**Figure 6:** Views of organisations (N = 47) on whether our proposals positively or negatively impact other individuals or groups





Patients and the public (51%) as well as pharmacy students/pre-registration trainees (49%) were frequently identified by organisational respondents as groups that would be positively impacted by the proposed changes. Organisations were, however, slightly less optimistic about the impact on pharmacy owners/employers and pharmacy professionals, with around a third (between 32% and 36%) indicating that these groups would be positively impacted.

Many organisational respondents thought that pharmacy owners/employers (40%) and pharmacy professionals (38%) would be both positively and negatively impacted by the proposals, while a modest proportion felt that patients and the public (21%) as well as pharmacy students/pre-registration trainees (28%) would be positively and negatively affected.

Only a small proportion of organisational respondents (between 4% and 9%) held the view that the proposals would have a negative impact the groups listed above. Equally, a small percentage of organisational respondents (ranging from 9% to 13%) indicated that there would be no impact.

Please see section 4 in the main body of the report for the chart showing the overall responses and further analysis.



# GPhC Equality guidance consultation

## Meeting paper for Council on 10 March 2022

Public business

### Purpose

To present to Council the consultation on the draft equality guidance.

### Recommendations

The Council is asked to:

- approve the consultation on the draft equality guidance

#### 1. Introduction

- 1.1 We have a legal duty, under the Equality Act, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between people from different groups, and foster good relations between people from different groups when carrying out all our day-to-day functions and activities as a public body.
- 1.2 Our newly published delivering equality, improving diversity and fostering inclusion (EDI) strategy (**Our strategy for change 2021–26**) sets out our intentions, and commitment, which includes the development of a comprehensive equality guidance for pharmacy owners.
- 1.3 The equality guidance will deliver on our objective under Theme 2 of the EDI Strategy, which relates to the use of our standards to proactively help tackle discrimination and to make sure everyone can access person-centred care, fostering equality of health outcomes.

#### 2. Our draft equality guidance

- 2.1 The draft guidance – attached at **Appendix 1** - is designed to help support pharmacy owners in understanding and meeting the **standards for registered pharmacies**.
- 2.2 To develop the guidance, we took note of the earlier feedback from the consultation on the EDI strategy, and also held internal and external workshops with our stakeholders which focused on the equality guidance. It also takes account of feedback from Council at an earlier workshop.
- 2.3 The draft guidance will help pharmacy owners to:
  - demonstrate that they are meeting our standards
  - help protect the rights of individuals

- advance equal opportunity for staff, patients, and the wider public, and
  - help improve the experience and healthcare outcomes of patients and members of the public using their pharmacy’s services.
- 2.4 The guidance is structured under the five principles in the standards for registered pharmacies and sets out some of the duties that pharmacy owners must observe under the Equality Act, including:
- **The ‘duty to make reasonable adjustments’** to the property from which services are provided, to meet the needs of people with disabilities (including patients, service users and employees)
  - **The duty to remove discrimination, harassment and victimisation**
- 2.5 As part of the draft guidance, we have included examples derived from the GPhC Knowledge Hub and inspections, which illustrate ways in which registered pharmacies are meeting their equality requirements. Pharmacy owners can use these examples to learn from others and to improve outcomes for people using their services.
- 2.6 The consultation will ask for views on the draft equality guidance and asks some important questions to sense-check our draft and to help us make it even more useful for pharmacy owners and pharmacy teams. The draft consultation document is attached at **Appendix 2**.

### 3. Timetable

- 3.1 The consultation, subject to Council approval, will be open for 8 weeks from 31 March to 26 May to provide an opportunity for feedback. An 8 week consultation period is considered appropriate for guidance. We have also already undertaken stakeholder engagement and have feedback from our consultation on the EDI strategy.

### 4. Equality and diversity implications

- 4.1 When developing our guidance, we have considered whether there are any significant equality implications, either positive or negative, for registrants or members of the public. We have not identified any significant negative equality or diversity implications of our proposals and expect there to be a positive benefit for patients and the public. However, the consultation provides an opportunity for respondents to provide feedback on any equality or diversity issues they wish to raise.

### 5. Communications

- 5.1 The consultation will be published on the GPhC’s website. It will also be sent to a wide range of stakeholders and communicated to the pharmacy media.
- 5.2 The consultation will run for 8 weeks and respondents will be able to respond online, by email or by post.
- 5.3 Alongside the online consultation, we will also engage with a broad and diverse range of stakeholders through various channels, including virtual focus groups, webinars and individual one-to-one meetings. This will include patient and pharmacy groups as well as equality networks and organisations.

### 6. Resource implications

- 6.1 The resource implications for this work have been accounted for in existing budgets.

## **7. Risk implications**

7.1 In our EDI strategy we have committed to develop a comprehensive equality guidance for pharmacy owners. The guidance will help to foster equality of health outcomes by proactively helping to tackle discrimination and promote access to person-centred care for everyone.

## **8. Monitoring and review**

8.1 The work outlined in the paper will be taken forward and Council will be kept updated on progress as part of ongoing Council business.

## **9. Recommendations**

The Council is asked to:

- approve the consultation on the draft equality guidance

Annette Ashley, Head of Policy and Standards  
General Pharmaceutical Council

Tejal Davda, Policy Manager (Standards)  
General Pharmaceutical Council

01/03/2022

# Equality guidance for pharmacies

# About this guidance

## Our role

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacies in England, Scotland and Wales. As part of our role, we set the standards that pharmacy professionals have to meet throughout their careers, as well as the standards that pharmacy owners are responsible for meeting, to ensure the safe and effective provision of pharmacy services at or from a registered pharmacy.

## Our commitment

In our [Vision 2030](#) and our [Strategic Plan 2020-25](#), we have committed to an anticipatory and proportionate approach to regulation. This means that we will be using data, intelligence and insights we hold and receive from others to help us get ahead of issues before they happen or become a bigger issue.

We have also committed to delivering equality, improving diversity and fostering inclusion in everything we do as a regulator and employer. This commitment to equality, diversity and inclusion (EDI) is set out in our [strategy for change 2021-2026](#).

Our EDI objectives are informed in a number of ways including through a growing understanding of the public we serve and the pharmacy professions we regulate. This includes:

- the pharmacy practice examples collected by our inspections team, which are held in the [GPhC Knowledge Hub](#)
- the feedback and concerns we receive from members of the public and others, telling us about their experiences of pharmacy
- the responses, reactions and feedback received in response to our [EDI strategy consultation](#),
- our earlier [research into Registration Assessment performance](#)

As the pharmacy regulator, we have a legal responsibility to promote equality and combat injustice in all aspects of our work, including in pharmacies. We must have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between people from different groups, and foster good relations between people from different groups when carrying out all of our day-to-day functions and activities as a public body.

## Purpose of this guidance

This guidance is designed to help support pharmacy owners in understanding and meeting the [standards for registered pharmacies](#). It should be read alongside the standards for registered pharmacies, which aim to create and maintain the right environment, both organisational and physical, for the safe and effective practice of pharmacy.

As part of the guidance, we have included several examples derived from the GPhC Knowledge Hub and inspections, which illustrate ways in which registered pharmacies are meeting their equality requirements. Pharmacy owners should use these examples to learn from others and think about how they can continuously improve outcomes for the people using their pharmacy's services.

The guidance does not list the legal duties under the Equality Act 2010 and the Human Rights Act 1998, as all pharmacy owners must meet their legal responsibilities in addition to their regulatory responsibilities to meet our standards. For further sources of information please see our other useful sources of information section at the end of this document.

By following this guidance, pharmacy owners will:

- demonstrate that they are meeting our standards
- help protect the rights of individuals
- advance equal opportunity for staff, patients, and the wider public, and
- help improve the experience and healthcare outcomes of patients and members of the public using their pharmacy's services.

In this document when we use the term 'staff' this includes:

- employees (registrants and non-registrants)
- agency and contract workers (including pharmacy locums), and
- any third party who helps the pharmacy provide any part of the pharmacy service and deals on behalf of the pharmacy owner with people who use pharmacy services.

## Who this guidance is for

Responsibility for making sure this guidance is followed lies with the pharmacy owner. In this document, the term 'you' means the pharmacy owner.

If the registered pharmacy is owned by a 'body corporate', the directors have responsibility. Those responsible for the overall safe running of the pharmacy need to consider the size and nature of the pharmacy, the range of services provided and, most importantly, the needs of patients and members of the public.

Everyone in the pharmacy team should be familiar with the guidance, including staff and managers with delegated responsibility. We also believe this guidance will be helpful for other organisations who employ pharmacy professionals or provide pharmacy services across a range of settings – regardless of whether we regulate those settings.

We expect this guidance to be followed. Not following the guidance might contribute towards you failing to meet one or more of the standards for registered pharmacies. This could result in us taking enforcement action – more information about this can be found in the GPhC's Registered pharmacies enforcement policy.

However, we recognise that the nature and scale of the pharmacy business has a significant impact on the resources and mechanisms used to meet our standards and guidance. We also recognise that there can be different ways to meet our standards proportionately and achieve the same outcomes for patients – that is, to provide safe and effective treatment, care and services.

If you do not follow this guidance, you should be able to show how your alternative ways of working safeguard patients, identify and manage any risks, and meet both our standards and any legal requirements.



# Introduction

## What is equality?

The Equality Act came into force in 2010, bringing together more than a hundred separate pieces of legislation into one single Act. It applies to everyone in Great Britain who provides goods, facilities or services to the public. This includes registered pharmacy premises.

Equality is about making sure that people, or groups of people, are not treated less favourably because of their protected characteristic(s). It is also about everyone having an equal opportunity to make the most of their potential. This may mean that, at times, people are not just treated 'the same', but in ways that reflect their individual needs and characteristics, and the inequality they may experience.

**The nine protected characteristics, as defined by the Equality Act 2010 (*For more information, please see Annex 1*).**

- **Age**
- **disability**
- **gender reassignment**
- **marriage and civil partnership**
- **pregnancy and maternity**
- **race**
- **religion or belief**
- **sex**
- **sexual orientation**

## The role of pharmacy owners

Pharmacy owners are responsible for ensuring the safe and effective provision of pharmacy services from a registered pharmacy. They are accountable for making sure that the standards for registered pharmacies are met, and for creating and supporting an environment in which pharmacy professionals can demonstrate their professionalism and deliver person-centred care.

There is a growing urgency, both societally and within pharmacy, to tackle all forms of inequality. As a service provider, it is essential that you create an environment where you protect the safety and welfare of both your team and patients, and work within the law.

This includes ensuring that no one is unlawfully discriminated against, in your workplace or when you provide services.

**There are four main types of discrimination** *For more information, please visit the EHRC website):*

- direct discrimination (i.e. treating one person worse than another person because of a protected characteristic)
- indirect discrimination (i.e. when an organisation's policy or way of doing things has a worse impact on someone with a protected characteristic than someone without one)
- harassment (i.e. treating people in a way that violates their dignity, or creates a hostile, degrading, humiliating or offensive environment); and
- victimisation (i.e. treating people unfairly if they decide to take action under the Equality Act, or if they support someone else who is doing so).

## Why is this important

In addition to being a legal and regulatory requirement, embedding the principles of equality and human rights in your pharmacy is the right thing to do.

A person-centred approach to care can improve the experience of people using your services, the care they receive, and the health outcomes of the whole community that you serve.

Your efforts to address health and workforce inequalities, and to remove the barriers that people face in their access to health and care, can also bring benefits to society and the wider economy. This can be measured in several ways, including:

- improved access to services, as some people may be more likely to seek care and support from pharmacies with whom they share some social or cultural characteristics
- lower levels of ill health amongst the local population
- higher productivity of staff
- improved staff morale and engagement
- greater staff loyalty and retention
- lower levels of sickness absence, absenteeism and presenteeism

Encouraging greater awareness and understanding of the different protected characteristics, alongside tackling discrimination, and prejudice, can also help to reduce the chance of unnecessary disciplinary and fitness to practise actions brought against your pharmacy. Complaints, grievances, and employment tribunal claims can be both costly and disruptive for your pharmacy.

Pharmacy owners can mitigate this sort of financial and reputational risk by meeting their equality and human rights responsibilities and by following the standards for registered pharmacies.

## Your obligations

### Legal obligations

All providers of public services need to comply with the Equality Act 2010 sections that relate to service provision and to employment.

As a service provider, you must comply with the law, which sets out the minimum legal obligations that you must meet, to remove potential discrimination, harassment, and victimisation. Equality law affects everyone responsible for running your business or who might do something on its behalf, including your staff.

The Equality Act 2010 introduces the 'duty to make reasonable adjustments' to the property from which services are provided to meet the needs of people with disabilities (including your employees). This duty recognises that bringing about equality for disabled people may mean changing the way in which services are delivered, providing extra equipment and/or the removal of physical barriers. Importantly, you must not pass on the costs of providing these adjustments to others.

The duty to make reasonable adjustments is 'anticipatory', meaning that you should think in advance (and on an ongoing basis) about what people with a range of impairments might reasonably need. These could include changes to the physical features of your pharmacy (i.e. the design, construction, entrance, exit, any fixtures, fittings, furnishings, etc.), the addition of an auxiliary aid, or the provision of assistance/changes to how information is provided.

What is reasonable, however, will depend on the size and circumstances of your pharmacy. The adjustments you make do not necessarily need to represent costly installations, or the introduction of permanent features. This might be unreasonable for the scale of your business, or impossible in the context of your premises. The reasonable adjustments should be adequate to the services you provide and the needs of the local population you serve.

Unlike for your patients and service users, the duty to make reasonable adjustments for your staff is not anticipatory. This means that you only have to make adjustments where you are aware that a worker has a disability. For example, this may be someone who is applying for a job at your pharmacy and requires an adjustment to help them through the application process, or it may be an existing member of your team who develops a disability. You must then take steps to remove, reduce or prevent the obstacles a disabled job applicant or worker might face in applying for, doing, or keeping their job.

## **Regulatory obligations**

Your regulatory obligations extend beyond strict compliance with the law.

We expect you to take the necessary steps to run your pharmacy in a way that encourages equality of opportunity and respect for diversity.

You are responsible for creating and supporting an environment in which pharmacy professionals can demonstrate their professionalism and deliver person-centred care that takes account of the diverse needs and cultural differences of the communities you serve.

We expect you to be fair and inclusive in your approach to everything you do, including the interactions with people you meet and deal with through the course of your work. This includes your relationship with patients, other healthcare professionals and service providers, and other people you work with.

As a pharmacy owner, you have an important role to play in implementing equality policies and procedures and in achieving fair outcomes. You must act with integrity and honesty, and in a way which is fair, inclusive, and transparent.

Where possible, your approach to equality should include everyone, including those who may face disadvantage because of their socio-economic background, their caring responsibilities, language barriers or other challenges.

As a pharmacy owner, you also have a responsibility to encourage diversity at all levels of your workforce.

# Equality and the GPhC standards for registered pharmacies

This guidance is set out under each of the five principles used in our standards for registered pharmacies.

## Principle 1: The governance arrangements safeguard the health, safety and wellbeing of patients and the public.

### 1.1 Identifying and managing risk

Pharmacy owners have an important responsibility to identify and manage the risks associated with providing pharmacy services.

A targeted risk assessment is a useful tool which can help you identify what in the pharmacy could prevent patients from accessing pharmacy services, or prevent staff from providing services, and what you need to do to keep this risk as low as reasonably practicable.

Risk assessments may apply across whole organisations but still need to consider the circumstances of each individual pharmacy. There is no requirement to carry out a specific, separate, risk assessment on an individual basis. However, if you become aware of a staff member or patient with a disability, another protected characteristic, or a related issue, which may put them at a disadvantage, you may need to review your existing risk assessment and overall governance arrangements to make sure it covers risks that might be present for them.

The findings of risk assessments should ideally provide clear recommendations, wherever appropriate, on how reasonable adjustments and timescales for implementing them are to be built into successful risk management.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

Example: Identifying and managing risk	
Context	What measures were taken?
Acknowledging that people from Black, Asian and Minority Ethnic (BAME) backgrounds, as well as some other groups, are being disproportionately affected by COVID-19, a pharmacy owner took steps to risk assess staff and patients.	<p>The pharmacy owner put appropriate arrangements in place to protect their staff, trainees, and their patients. Occupational risk assessments helped identify at-risk and vulnerable people within the team, including staff from BAME backgrounds, along with other vulnerable groups, such as those with existing health conditions.</p> <p>For patients that were exceptionally vulnerable, the owner put provisions in place that meant they were able to deliver the patient's medication to their residence, rather than coming into the pharmacy.</p>

### Example: Identifying and managing risk

[Please note: as we state in our **EDI strategy** with reference to the use of the term BAME (Black, Asian and minority ethnic), we recognise the recent debates and different perspectives about the use and limitations of this term, specifically that it should not be taken as referring to a singular group or identity. We are committed to taking a nuanced approach to issues of race and ethnicity as far as possible, whilst at the same time working with our stakeholders to determine the terminology to support our approach going forward.

## 1.2 Reviewing and monitoring the arrangements in place

Pharmacy owners should regularly review and monitor the safety and quality of pharmacy services, and whenever circumstances change – for example, when significant business or operational changes are made.

Any changes to your governance arrangements, systems or policies have the potential to disproportionately disadvantage certain groups or individuals, and therefore need to be carefully monitored. Similarly, if the existing arrangements have been in place for a while, pharmacy owners should ensure that they remain fit for purpose and do not adversely impact on certain groups or individuals.

Ahead of introducing any new practices, policies, or procedures, you may also wish to consider whether an Equality Impact Assessment (EIA) should be carried out. An EIA is an analysis of a proposed organisational policy, or a change to an existing one. Its aim is to assess whether the policy has a disproportionate impact on people who share one or more of the protected characteristics. EIAs are often carried out by public bodies to help them comply with their equality duties, but they can also be a useful tool for you to use in your pharmacy.

Carrying out an EIA is an example of good equality practice. However, it does not necessarily need to take the form of a written document, called an “EIA”. If you have based your decisions on evidence, thought about any unintended impacts and how to mitigate these, and kept a record of your decisions, you should be able to demonstrate that you have taken equality considerations into account.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

### Example: Reviewing and monitoring arrangements

Context	What measures were taken?
A community pharmacy was considering a complete refit of the premises. As part of this, the owner was looking to implement a new process where the dispensing would be highly automated using two robots.	<p>The pharmacy owner sought feedback from a wide range of patients, including those sharing protected characteristics, to ensure that any changes would not impact on their ability to access pharmacy services. An equality impact assessment was also carried out.</p> <p>Procedures were developed to ensure that any issues were adequately captured once the changes had been implemented.</p> <p>All services were risk assessed before commencing, and on an ongoing basis to ensure that risks were managed.</p> <p>Improvements have been demonstrated by making comparisons between the new services and technology, once introduced, and the previous arrangements.</p>

### 1.3 Staff with clearly defined roles and accountability

Pharmacy owners are responsible for making sure that pharmacy services are provided by staff with clearly defined roles and clear lines of accountability. There should be transparency and fairness when it comes to allocating roles or promoting staff, and when applying policies in the pharmacy.

In the spirit of fairness and proportionality, it is good practice to put in place policies and procedures which consider the size and circumstances of your pharmacy.

You should consider developing a clear equality policy for your staff and the people using your services. Having an equality policy is not mandated by law, but it demonstrates good equality practice and lets everyone know that this is something you take seriously. It provides visibility and reassurance for your staff, as well as for patients and members of the public, that you are committed to equality and diversity in everything you do as an employer and service provider.

Your policy should spell out your commitment to the principles of equality, as well as setting out any legal requirements. A statement of this kind normally defines your workplace culture and could clearly set out that discrimination and harassment will not be tolerated in your pharmacy. It should cover every aspect of running a pharmacy, from recruitment through to pay and benefits, training and management, discipline, and grievance procedures.

You should make sure that your staff understand their equality obligations, by providing them with dedicated training. This training should cover: equality law, an explanation of the protected characteristics, a definition of acceptable and unacceptable behaviour and personal liability, as well as your own equality policy.

You should also consider other training that could be useful and appropriate, including training around cultural competence and decision-making.

Staff who understand their roles and responsibilities in relation to equality can provide good service, make informed decisions, and feel able to raise concerns, if needed.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

Example: Staff with clearly defined roles and accountability	
What is the challenge?	What measures were taken?
<p>Patients have reported that they are not always clear on the roles, qualifications, and expertise of pharmacy staff. If patients have an issue or need to ask for advice, they would like to easily identify the correct member of staff.</p> <p>This is especially true for people with learning disabilities, who benefit from clear, simple, and possibly repeated explanations and instructions.</p>	<p>Job titles and photos of staff responsible for specific services were displayed in the pharmacy to help people using those services. This was particularly helpful for people with learning disabilities.</p> <p>The pharmacy owner must make sure that staff roles and responsibilities are clearly defined and understood. They need to ensure that staff have undergone equality training and are able to identify people coming into the pharmacy who may require additional support.</p> <p>Staff also need to be aware of the requirement to follow the NHS <b><u>Accessible Information Standard</u></b>, which aims to make sure that people who have a disability, impairment or sensory loss are provided with information in an accessible format, and supported to use it.</p>

### 1.4 Openness to feedback and action on concerns

Pharmacy owners should be receptive to staff and patient feedback and concerns, and take these into account, when appropriate. This includes any reports of unfair treatment and discrimination. As an employer, you are legally responsible if acts of discrimination, harassment and victimisation are carried out by your staff during their work. This can be avoided if you tell your staff what is expected of them and how equality law applies to what they are doing. A way of informing them about equality law would be via your equality policy, dedicated equality training, and via their terms of employment. Doing this will allow you to show that you have taken reasonable steps to prevent unlawful discrimination and harassment occurring.

If someone does complain, you should investigate what has taken place. If appropriate, you may also need to discipline the person who has unlawfully discriminated against or harassed someone else.

You should have a clear complaints policy, to make sure that all complaints, including those of discrimination, harassment and victimisation are dealt with promptly, fairly, openly, and effectively.

### 1.5 Appropriate indemnity or insurance arrangements

To comply with equality legislation, all organisations providing goods, facilities or services to the public must consider making reasonable adjustments to their practices and the services they deliver. The duty

to make reasonable adjustments aims to make sure that disabled people can experience services to a standard as close as possible to that usually offered to non-disabled people.

A pharmacy could provide reasonable adjustments for elderly or disabled patients in the form of compliance aids, such as: multi-compartment compliance aids, easy open containers, reminder charts/alarms, dexterity aids, winged or plain bottle caps. However, you shouldn't assume that a patient will necessarily benefit from such an adjustment. It is important to establish the need, suitability of an adjustment, as well as the preference of the patient.

Once an adjustment has been made, the responsibility for the decision lies with the pharmacy and the pharmacist. Should the adjustment cause harm (for example, a reminder chart that the patient is not able to understand, or a Monitored Dosage System which results in incompatibilities or deterioration of the medicines), this could lead to professional liability and indemnity claims against the pharmacy.

## **1.6 Maintaining all necessary records for the safe provision of pharmacy services**

You must make sure that all pharmacy records required by law, including any necessary to comply with your equality obligations, are maintained and updated, to demonstrate that services in your pharmacy are provided safely and effectively.

## **1.7 Protecting the privacy, dignity and confidentiality of patients and the public**

Pharmacy owners should make sure that sensitive information is managed to protect the privacy, dignity, and confidentiality of their staff, as well as of patients and the public who receive pharmacy services.

This is particularly important in the context of EDI information. Such information is sensitive personal data and individuals always have a right for it to be kept confidential and protected. For example, if members of the pharmacy team are aware of an individual's medical history or circumstance, they should ask the concerned individual for permission before passing this information on to someone else.

Utmost care should also be taken regarding your staff's EDI information. Although it is not a legal requirement, monitoring the profile of your staff will demonstrate your commitment to equality. It can also help you understand the composition of your workforce and their different needs, as well as shine a light on any areas for improvement.

You should only collect information that you can use effectively, and you should have a statement which makes it clear to your employees, and any new job applicants, why you are collecting this information. You should have robust procedures in place for how equality information is collected, stored, and analysed. You must make sure that the information collected is processed fairly and lawfully, and in accordance with the **Data Protection Act 1998**.

You may decide to collect information anonymously, which might increase the likelihood of people volunteering their data. In any case, you need to reassure them that the information they provide will never be used to discriminate against them.

## **1.8 Safeguarding children and vulnerable adults**

The need to safeguard vulnerable service users often overlaps with your responsibilities under equality legislation.

You should consider whether you have the right systems and policies in place to handle confidential information and communicate with any relevant agencies. You should also consider whether you



provide the right environment where patients and members of the public feel safe to share concerns and disclose personal information.

Safeguarding issues can arise in different circumstances and can impact on several groups, including children and the elderly; women, who may or may not be pregnant; and transgender people. They could also affect people based on their race, religion or sexuality. Being able to identify warning signs and take appropriate action is a key element of your pharmacy's provision of safe and effective services to patients and the public.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

Example: Safeguarding children and vulnerable adults	
Context	What measures were taken?
<p>Amongst other services, the pharmacy provided a range of extended services for people with dementia and their families.</p> <p>There were many patients in the community suffering from dementia of varying degrees, so a need was identified for improved local provision and staff/patient/carer knowledge.</p>	<p>One of the pharmacists decided to undertake personal training and development, and became involved with other healthcare professionals, including specialists, on a dementia project.</p> <p>The pharmacist developed a checklist of topics to be considered in pharmacies to make them 'dementia friendly', initially for use in their pharmacy. This was later developed into a toolkit for use in all pharmacies, which included: training material for pharmacy staff, agencies to signpost patients to, and an audit to undertake in the pharmacy to assess its 'dementia friendliness'. The toolkit was shared with the Royal Pharmaceutical Society as a resource; it was also used by a University and trialled in some local pharmacies.</p> <p>The pharmacy linked with Alzheimer's Scotland and all staff in the pharmacy were trained by one of their outreach workers.</p> <p>A clinic was set up in the pharmacy. This weekly drop-in session for patients, carers, and families to access support and signposting was well attended and became very popular.</p> <p>Local businesses regularly signposted their customers to the pharmacy. The pharmacy also won an award for the Best Independent Community Pharmacy for Innovation for their work in dementia.</p>

## Principle 2: Staff are empowered and competent to safeguard the health, safety and wellbeing of patients and the public.

### 2.1 Enough suitably qualified and skilled staff

The number of staff and the skill mix required for the safe and effective provision of services depends on the size, workload, and context of your pharmacy. However, it is important that there is a staffing plan, including any contingency plans, as well as ongoing reviews of the staffing levels and the required skills and qualifications of staff members. This should include considerations about equal opportunities for

candidates to apply and access different roles or positions, making sure that those with one or more protected characteristics are not disadvantaged or discriminated against.

Equality law allows you, as an employer, to take ‘positive action’ before or at the application stage. Positive action refers to the steps you can take to encourage applications from groups of people with different needs or with a past track record of disadvantage or low participation. This could apply, for example, if the make-up of your team is different to the make-up of the local population and you want to encourage more candidates with a protected characteristic (e.g. age, race, etc.) to apply.

We recommend that you read and carefully follow the **advice from the Equality and Human Rights Commission (EHRC) on positive action**, so you can get this right.

## 2.2 Staff with appropriate skills, qualifications and competence for their role and the tasks they carry out

The pharmacy owner is responsible for making sure that all staff are properly trained and competent to provide medicines and other pharmacy services safely. They should also undertake any necessary training for the safe and effective provision of services, including equality training.

In your capacity as an employer, you must make sure that the opportunities you offer for training and development are free from unlawful discrimination. When deciding on training opportunities, focus on the individual needs of your team members, rather than on their protected characteristics and your assumptions about these. For example, when considering training, do not overlook pregnant members of staff or those on maternity or paternity leave.

Try to be flexible about the training opportunities you provide to your employees. This means making sure that the style, timing or location of the training does not put anyone who shares a protected characteristic at a disadvantage.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

Example: Staff with appropriate skills, qualifications and competence for their role	
Context	What measures were taken?
The pharmacy owner made sure that their induction and training programmes reflected their EDI commitments, and supported staff in identifying and achieving their learning goals.	<p>A comprehensive induction programme was in place for new members of the team, including on the pharmacy’s equality and diversity, whistleblowing, and complaints policy.</p> <p>There was a programme in place, where newer team members could shadow more experienced colleagues when learning various tasks. The pharmacy had also introduced a ‘buddy’ system to support colleagues in training roles.</p> <p>The Superintendent Pharmacist (SI) led regular training sessions with all the team and pharmacy team members had access to different training modules. Pharmacy team members regularly shared information related to healthy living topics and held regular conversations and team meetings.</p>

### Example: Staff with appropriate skills, qualifications and competence for their role

The pharmacy had 'Training Request' forms and these forms were available for team members if they wanted any specific training or further support. Team members could state if they would benefit from one-to-one learning and if they were able to complete additional training outside their contracted hours. This provided flexibility to employees and accommodated those with disabilities, religious commitments, or caring responsibilities.

The decision by the pharmacy owner to invest time and effort in staff training meant that staff were well placed to provide safe and effective services to patients and the public, and that they treated everyone with dignity and respect.

### 2.3, 2.4, 2.5 Empowered staff and an open learning culture

As the pharmacy owner, you are responsible to ensure that staff can always comply with their own professional and legal obligations. They must feel empowered to provide feedback and raise concerns, including about discrimination, without fear of harassment or victimisation.

The culture in your pharmacy will depend on your leadership. If you demonstrate your commitment to equality and human rights from the start of their employment and make it part of your organisational culture, your staff will feel motivated, and you will be able to attract and keep valuable workers. If treating everyone with dignity and respect is the way of doing things in your pharmacy, you are much less likely to experience a case of discrimination, bullying or harassment brought against you and your team.

An open and inclusive culture, free from harassment and prejudice, will be the foundation for a committed pharmacy team, who apply the principles of equality and human rights in their work.

If a member of your team wishes to complain about discrimination, they might raise this to you, or make a claim in an Employment Tribunal. It would be desirable to avoid the latter, which could be lengthy, costly, and damaging to your pharmacy's reputation. You could avoid this by instilling confidence among your staff that their complaints about discrimination would be taken seriously. They should know how to raise a concern – informally, or via a set grievance procedure – and that there would be consequences if someone has discriminated unlawfully. They should also feel able to seek advice internally or externally (from a range of unions, charities, the GPhC, or other bodies), prior to deciding on whether or not to raise a concern.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

### Example: Empowered staff and an open learning culture

What is the challenge?	What measures were taken?
A concern was raised by a member of staff about the unprofessional and discriminatory behaviour	The pharmacy owner investigated the complaint by speaking with other members of

### Example: Empowered staff and an open learning culture

of one of their pharmacist colleagues. This was based on observation of the pharmacist's attitude towards the complainant and others.

The complainant reported experiencing severe distress and self-harming due to the incessant harassment of the pharmacist in question.

the team and the registrant in question, observing their behaviour and taking the necessary steps to address the concerns raised.

Steps included a refresh of the equality training for all members of staff and a reminder about the different ways of raising a concern, for both employees and members of the public.

The complainant received a formal apology and received support with their mental health.

The pharmacy owner had to make a decision whether disciplinary action was necessary. It was decided that the steps that had already been taken which included the additional training and the apology, were appropriate in this case.

### Principle 3: The environment and condition of the premises from which pharmacy services are provided, and any associated premises, safeguard the health, safety and wellbeing of patients and the public.

You must make sure that your pharmacy premises are safe and suitable for the provision of services to patients and members of the public. When planning and reviewing the suitability of your premises, you should be mindful of the needs of people with different protected characteristics, including those with mobility or comprehension issues.

You must make sure that nobody is unlawfully discriminated against, harassed or victimised when using your premises. This is dependent on the awareness and attitude of your staff, but also on the environment in your pharmacy, and how it works to protect the privacy, dignity and confidentiality of the people you serve.

Examples of what pharmacies have done to address these issues are provided in the box below. These may not apply in all situations and there may be other ways to address these issues.

#### Examples: The environment and condition of the premises

- A pharmacy provided private booths for COVID-19 vaccinations. This helped protect people's privacy and dignity if they needed to remove any items of clothing before being vaccinated. This was particularly important for people from the local BAME community.
- Cordless telephones were used in one pharmacy to allow staff to hold private conversations away from the public area. This was particularly important for people wanting to discuss sensitive issues, such as: aspects of their chronic condition; gender reassignment; or the impact of religious fasting on their health and wellbeing.

### Examples: The environment and condition of the premises

- The consultation room in a pharmacy was an appropriate size to accommodate people, as well as their carers, parents or chaperones, and its door was wide enough to allow access for people with mobility difficulties. The room was clean, clutter free and well signposted, for the convenience of people with cognitive or visual impairments. Its use was routinely promoted by pharmacy team members to people visiting the pharmacy.
- One pharmacy had multiple systems in place to obtain regular feedback from patients. This included an annual survey, as well as anonymous feedback sought through regular mystery shopper audits. The results from the surveys were reviewed by the pharmacy team, and the points of feedback raised were identified and utilised to inform the layout and design of the pharmacy. This had recently included: the installation of an automatic door for greater accessibility; a dedicated seating area for people waiting for services; and the installation of a suitably sized consultation room, and a separate consultation pod, enabling the multiple services delivered by the pharmacy to be conducted in a private and confidential manner.

## Principle 4: The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public

### 4.1 Accessible pharmacy services

You are responsible for making sure that your services are accessible to patients and the public. This includes not only the physical accessibility of your premises, but also the availability and adequate provision of services, at the right time, in the right place, and in the right way.

A thorough and ongoing risk and equality impact assessment will allow you to assess the accessibility of your pharmacy premises, considering any reasonable adjustments you may need to make.

Such adjustments may also be considered for other people sharing one or more of the protected characteristics – for example, older people visiting your pharmacy, or pregnant members of staff.

You should think about every aspect of your premises, including:

- how people enter and find their way around in the pharmacy
- how they communicate with staff
- any signage and information you provide
- any desks, counters and/or waiting areas

If you provide some or all your services over the internet, you also need to think about the accessibility of your virtual “premises” – your website – and to make sure it is free from discrimination. For example, you mustn’t allow any discriminatory information or advertisements to appear on your website, and you must make reasonable adjustments to ensure that your website is accessible to disabled people.

### Examples: Reasonable adjustments

- Providing lifts, wide/automatic doors, handrails or ramps for people with mobility issues
- Designating parking spaces for people with disabilities

### Examples: Reasonable adjustments

- Providing tactile signage and printed information in different formats for people with visual impairments
- Providing a hearing loop system for people with hearing impairments
- Making sure the entrance/exit is a different colour, or otherwise easily identifiable by people entering the pharmacy to assist visually impaired and partially sighted people, as well as people with learning disabilities
- Making sure there is clear signage in the pharmacy
- Providing clear instructions and personal assistance for people with learning disabilities, such as form filling
- Making use of pictograms to aid people with learning difficulties or speakers of other languages
- Make use of translation services for people with limited English proficiency
- If you have a website, providing text-to-speech software for people with visual impairments, or other adjustments to meet the needs of people with manual dexterity impairments (e.g. if they cannot use a mouse), those with dyslexia and learning difficulties.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

### Example: Safe and accessible pharmacy premises

Context	What measures were taken?
<p>This shopping centre pharmacy carried out targeted risk assessments and actively considered the needs and demographics of its local community, to ensure ease of access to its premises and services.</p>	<p>There was good physical access to the pharmacy by means of a flat entrance which was open onto a flat shopping centre. Wide aisles allowed prams, wheelchairs, and people with disabilities to move about easily in the pharmacy. There was a low reception desk at the end of the dispensary which allowed wheelchair access, enabling patients to reach a desk to sign prescriptions and receive their medication.</p> <p>A hearing loop in working order was available and staff had strategies to ensure that patients who were hard of hearing understood how to use their medicines.</p> <p>Large print labels were provided for some patients and large numbers were on labels with corresponding direction sheets for those who required large print. Other strategies used to assist patients included labelling some eye drops on the bottle and some on the carton to differentiate the different types, halving tablets, and repackaging tablets from blisters into bottles with plain tops. All these strategies were risk assessed and notes were made on the Patient Medication Record (PMR) to ensure that these were always supplied in this manner.</p>

## 4.2 Safe and effective pharmacy services

Having an equality policy in place and making sure that everyone involved in the delivery of services has undergone equality training will help avoid unlawful discrimination and promote equality. Members of your team will be aware of the principles of equality and will be able to provide more time, targeted care, or adequate assistance to those who need it.

You are also responsible for making sure that your pharmacy services are inclusive and responsive to the diverse needs and cultural differences of the communities you serve. You must be satisfied that people sharing any of the protected characteristics are not disadvantaged, and that the care they receive is not compromised by gaps in your service provision or by insufficient awareness of their specific needs. For example, you could consider adding visual cues, such as inclusivity posters, to make sure that everyone feels welcome in your pharmacy, and to reassure them that they will be treated with dignity and respect.

Pharmacies are in a unique position, compared to other health and care services, as they are in the heart of local communities and are best placed to observe and address health inequalities among the local population. These unfair and avoidable differences in physical health outcomes, mental wellbeing and life expectancy have been exacerbated by the COVID-19 pandemic.

It is within your reach to assess the needs of people coming into your pharmacy every day and the issues they are facing. These may be specific to certain socio-economic or ethnic groups.

Your role in tackling health inequalities could involve a targeted and better-informed use of primary care and public health services, and prevention initiatives. It could also involve the support of local community and faith leaders and the use of your staff's expertise and cultural awareness. For example, their ability to speak languages commonly used in the area can help address language and communication barriers and varying levels of literacy. Making use of speakers of other languages can help make sure that people receiving pharmacy services have the information they need, in an accessible way, about their medication and how to take them.

A common trait of excellent and outstanding services is how person-centred they are, the willingness of staff to listen to people, and to proactively identify and respond to their current and prospective needs. For example, if you become aware that certain groups of people face a disadvantage, you will demonstrate good practice if you consider and target your interventions to address these needs.

As with everything you do, we would expect you to exercise due diligence and have the right governance arrangements in place to support your actions and any special interventions you may choose to use.

The example below illustrates how pharmacy owners can meet this requirement. It may not apply in all situations and there may be other ways to meet this requirement.

Example: Safe and effective pharmacy services	
Context	What measures were taken?
The pharmacy worked with external stakeholders to identify and attempt to overcome the barriers to	The lead pharmacist worked with local community leaders to identify locations that could be used as outreach clinics from which to administer the vaccination. As people already trusted their local leaders, they were more likely to use the outreach clinics.

### Example: Safe and effective pharmacy services

COVID-19 vaccination amongst groups within the local Black, Asian and Minority Ethnic (BAME) community.

As a result of these conversations, the lead pharmacist was working with NHS England to amend the current contract to enable the vaccination to be administered in different associated sites.

The pharmacist also worked with the local media to dispel 'fake news' from social media, historical myths and nervousness, and to try and increase the uptake amongst some groups within the local BAME population.

People using the service were provided with a private space for vaccination, which preserved their dignity, and could also choose to be vaccinated by someone of a particular gender. There were pharmacy team members who spoke different languages, so they could explain the process if English was not the person's preferred language.

## Principle 5: The equipment and facilities used in the provision of pharmacy services safeguard the health, safety and wellbeing of patients and the public.

Just like with your pharmacy premises, the equipment and facilities used in your pharmacy must be safe and suitable for the provision of pharmacy services. This includes any equipment and facilities used as reasonable adjustments to meet the needs of patients and service users, as well as those of your staff.

In the case of adjustments made for your staff, whether these are linked to disability or another protected characteristic (e.g. pregnancy), it is advisable to discuss these with the specific member of staff to determine their suitability and effectiveness.



## Other useful sources of information

- Advisory, Conciliation and Arbitration Service (ACAS), <https://www.acas.org.uk/>
- CQC (2018) “Equally outstanding Equality and human rights – good practice resource How can a focus on equality and human rights improve the quality of care in times of financial constraint?”, [https://www.cqc.org.uk/sites/default/files/20181010\\_equally\\_outstanding\\_ehr\\_resource\\_nov18\\_accessible.pdf](https://www.cqc.org.uk/sites/default/files/20181010_equally_outstanding_ehr_resource_nov18_accessible.pdf)
- CQC (2019) Declare Your Care: People from black and ethnic minority communities, <https://www.cqc.org.uk/help-advice/your-stories/declare-your-care-people-black-ethnic-minority-communities>
- Commission on Race and Ethnic Disparities (2021) The report of the Commission on Race and Ethnic Disparities, <https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities>
- Culturally competent person-centred care, CPPE, <https://www.cppe.ac.uk/gateway/cultcomp>
- Diverse Cymru, <https://www.diverseecymru.org.uk/>
- Equality Act 2010, [https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga\\_20100015\\_en.pdf](https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf)
- Equality and Human Rights Commission, <https://www.equalityhumanrights.com/en>
  - Equality Act guidance, <https://www.equalityhumanrights.com/en/advice-and-guidance/equality-act-guidance>
  - Public Sector Equality Duty, <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty>
  - What are reasonable adjustments?, <https://www.equalityhumanrights.com/en/advice-and-guidance/what-are-reasonable-adjustments>
- Equally Ours, <https://www.equallyours.org.uk/>
- GPhC, Delivering equality, improving diversity and fostering inclusion: our strategy for change 2021 – 2026, [https://www.pharmacyregulation.org/sites/default/files/document/council\\_meeting\\_papers\\_11\\_march\\_2021.pdf#page=36](https://www.pharmacyregulation.org/sites/default/files/document/council_meeting_papers_11_march_2021.pdf#page=36)
- GPhC, Knowledge hub for the pharmacy team, <https://inspections.pharmacyregulation.org/knowledge-hub>
- Health and Safety Executive, <https://www.hse.gov.uk/>
- Health Watch (2021) COVID-19: What can pharmacists learn from people’s experiences of services?, [https://www.healthwatch.co.uk/news/2021-08-23/covid-19-what-can-pharmacists-learn-peoples-experiences-services?mc\\_cid=79a83a0610&mc\\_eid=66b39c3236](https://www.healthwatch.co.uk/news/2021-08-23/covid-19-what-can-pharmacists-learn-peoples-experiences-services?mc_cid=79a83a0610&mc_eid=66b39c3236)
- Joint National Statement of Principles on Inclusive Pharmacy Professional Practice, September 2020,

- <https://www.rpharms.com/Portals/0/Joint%20National%20Statement%20of%20Principles%20Final%20Version.pdf?ver=2020-09-24-170517-123>
- Joint National Plan for Inclusive Pharmacy Practice in England, March 2021, <https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Inclusive%20Pharmacy%202021/Joint%20National%20Plan%20for%20Inclusive%20Pharmacy%20Practice%20-%202010%20March.pdf>
  - LGBT Foundation (2020) Hidden Figures: Hidden Figures: LGBT Health Inequalities in the UK, <https://dxfy8lrzbpwyr.cloudfront.net/Files/b9398153-0cca-40ea-abe-bf7d7c54d43af/Hidden%2520Figures%2520FULL%2520REPORT%2520Web%2520Version%2520Smaller.pdf>
  - LGBT Foundation (2021) Good practice guide to monitoring sexual orientation and trans status 2021, <https://dxfy8lrzbpwyr.cloudfront.net/Files/d1edc08d-1514-4df8-8bf0-ebc97a79e4e0/If%2520We%25E2%2580%2599re%2520Not%2520Counted%2c%2520We%2520Don%25E2%2580%2599t%2520Count%2520FINAL.pdf>
  - LGBT Foundation (2020) Hidden Figures: The impact of the COVID-19 pandemic on LGBT communities in the UK, May 2020, 3<sup>rd</sup> edition, <https://dxfy8lrzbpwyr.cloudfront.net/Files/7a01b983-b54b-4dd3-84b2-0f2ecd72be52/Hidden%2520Figures-%2520The%2520Impact%2520of%2520the%2520Covid-19%2520Pandemic%2520on%2520LGBT%2520Communities.pdf>
  - National Literacy Trust, Adult literacy, <https://literacytrust.org.uk/parents-and-families/adult-literacy/>
  - NHS Accessible Information Standard, <https://www.england.nhs.uk/ourwork/accessibleinfo/>
  - NHS England (2019) Guidance for Commissioners: Interpreting and Translation Services in Primary Care, <https://www.england.nhs.uk/publication/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care/>
  - NHS Records Management Code of Practice 2021, <https://www.nhsx.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice-2021/>
  - NHS Scotland (2020) Interpreting, communication support and translation national policy, <http://www.healthscotland.scot/media/3304/interpreting-communication-support-and-translation-national-policy.pdf>
  - NHS Staff Management and Health Service Quality, Independent report (2011), <https://www.gov.uk/government/publications/nhs-staff-management-and-health-service-quality>
  - NMC (2017) The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process, <https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/bme-nurses--midwives-ftp-research-report.pdf>
  - Nuffield Trust (2021) Ethnicity coding in English health service datasets, [https://www.nuffieldtrust.org.uk/files/2021-06/1622731816\\_nuffield-trust-ethnicity-coding-web.pdf](https://www.nuffieldtrust.org.uk/files/2021-06/1622731816_nuffield-trust-ethnicity-coding-web.pdf)

- Pharmacist Support, <https://pharmacistsupport.org/>
- Pharmacists' Defence Association, <https://www.the-pda.org/>
- PSNC briefing: Equality Act 2010, January 2016, <https://psnc.org.uk/wp-content/uploads/2016/01/PSNC-Briefing-001.16-Equality-Act-2010.pdf>
- Public Health England, Guidance: Pharmacy and people with learning disabilities: making reasonable adjustments to services, <https://www.gov.uk/government/publications/pharmacy-and-people-with-learning-disabilities/pharmacy-and-people-with-learning-disabilities-making-reasonable-adjustments-to-services>
- Public Health England (2017) Language interpreting and translation: migrant health guide, <https://www.gov.uk/guidance/language-interpretation-migrant-health-guide#history>
- Public Health England (2017) Reducing health inequalities: system, scale and sustainability, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/731682/Reducing\\_health\\_inequalities\\_system\\_scale\\_and\\_sustainability.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf)
- Public Health England (2021) Pharmacy teams – seizing opportunities for addressing health inequalities, <https://psnc.org.uk/wp-content/uploads/2021/09/Pharmacy-teams-seizing-opportunities-for-addressing-health-inequalities.pdf>
- Royal Pharmaceutical Society, <https://www.rpharms.com/>
  - RPS, Improving Inclusion and Diversity across our profession: our strategy for pharmacy 2020 – 2025, <https://www.rpharms.com/LinkClick.aspx?fileticket=plJ2cLMj2H4%3D&portalid=0>
- The Diversity Trust, <https://www.diversitytrust.org.uk/>
- The Equality Trust, <https://equalitytrust.org.uk/>
- The Health Foundation (2014) Ideas into action: person-centred care in practice, <https://www.health.org.uk/publications/ideas-into-action-person-centred-care-in-practice>
- Welsh Government (2019) More than just words: Welsh in the workplace, <https://gov.wales/sites/default/files/publications/2019-04/follow-on-strategic-framework-for-welsh-language-services-in-health-social-services-and-social-care-2016-2019.pdf>

# Annex 1: The nine protected characteristics

PROTECTED CHARACTERISTIC (Equality Act 2010)	DEFINITION	<u>RESOURCES</u>
<b>AGE</b>	<p>A person belonging to a particular age, or a range of ages.</p> <p>Age discrimination could be based on someone’s actual or perceived age, or on their connection to someone of a specific age or age group.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Age UK</a></li> <li>• <a href="#">Centre for ageing better</a></li> <li>• <a href="#">Older people, CPPE</a></li> <li>• <a href="#">Independent Age</a></li> <li>• <a href="#">Children’s Rights Alliance for England</a></li> </ul>
<b>DISABILITY</b>	<p>A physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative impact on a person’s ability to do normal daily activities. Substantial means the impairment is more than trivial, while long-term means the impairment must have lasted for the last year, or be expected to last for 12 months or more.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Access to Work government scheme</a></li> <li>• <a href="#">Business Disability Forum</a></li> <li>• <a href="#">Consulting with people with physical disabilities programme, CPPE</a></li> <li>• <a href="#">Disability Confident scheme</a></li> <li>• <a href="#">Disability Matters</a></li> <li>• <a href="#">Disability Rights UK</a></li> <li>• <a href="#">Enhance the UK</a></li> <li>• <a href="#">Hidden disabilities UK</a></li> <li>• <a href="#">Learning disabilities programme, CPPE</a></li> <li>• <a href="#">MIND</a></li> <li>• <a href="#">Rethink Mental Illness</a></li> <li>• <a href="#">NHS Workforce Disability Equality Standard</a></li> <li>• <a href="#">College of Mental Health Pharmacy</a></li> <li>• <a href="#">PDA Disabled Pharmacists' Network (Ability)</a></li> <li>• <a href="#">SCOPE</a></li> </ul>

PROTECTED CHARACTERISTIC (Equality Act 2010)	DEFINITION	RESOURCES
<b>GENDER REASSIGNMENT</b>	<p>The process of transitioning from one sex to another.</p> <p>Gender reassignment discrimination is when a person is treated differently because they are transsexual. To be protected from gender reassignment discrimination, one does not need to have undergone any specific treatment or surgery to change from their birth sex to their preferred gender. They can be at any stage in the transition process – from proposing to reassign their gender, to undergoing a process to reassign their gender, or having completed it.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Mermaids</a></li> <li>• <a href="#">National Center for Transgender Equality</a></li> <li>• <a href="#">Sparkle</a></li> <li>• <a href="#">Transgender Law Center</a></li> <li>• <a href="#">Gender Identity Research &amp; Education Society</a></li> <li>• <a href="#">Transgender healthcare - consulting with dignity and respect, CPPE</a></li> </ul>
<b>MARRIAGE AND CIVIL PARTNERSHIP</b>	<p>Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners and same-sex couples must not be treated less favourably than other married couples (except where permitted by the Equality Act).</p>	<ul style="list-style-type: none"> <li>• <a href="#">Marriage and civil partnership discrimination, Citizens Advice</a></li> </ul>

PROTECTED CHARACTERISTIC (Equality Act 2010)	DEFINITION	RESOURCES
<b>PREGNANCY AND MATERNITY</b>	<p>Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Maternity Action</a></li> <li>• <a href="#">MumsAid</a></li> <li>• <a href="#">Pregnant then Screwed</a></li> <li>• <a href="#">British Pregnancy Advisory Service (BPAS)</a></li> <li>• <a href="#">Working Families</a></li> <li>• <a href="#">Families need Fathers</a></li> </ul>
<b>RACE</b>	<p>Race refers to a group of people defined by their race, colour, and nationality (including citizenship). Race also covers ethnic and racial groups.</p> <p>A racial group can be made up of two or more distinct racial groups, for example black Britons, British Asians, British Sikhs, British Jews, Romany Gypsies and Irish Travellers.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Runnymede Trust</a></li> <li>• <a href="#">Race Equality First</a></li> <li>• <a href="#">Race Equality Foundation</a></li> <li>• <a href="#">Race Equality Matters</a></li> <li>• <a href="#">NHS Race and Health Observatory</a></li> <li>• <a href="#">NHS Workforce Race Equality Standard</a></li> <li>• <a href="#">PDA BAME (Black, Asian and Minority Ethnic) Pharmacists' Network</a></li> </ul>
<b>RELIGION OR BELIEF</b>	<p>Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect a person's life choices or the way they live for it to be included in the definition.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Christian Aid</a></li> <li>• <a href="#">Christian Medical Fellowship</a></li> <li>• <a href="#">Hindu Council UK</a></li> <li>• <a href="#">Islamic Relief</a></li> <li>• <a href="#">The Jewish Council for Racial Equality</a></li> <li>• <a href="#">Institute of Jainology</a></li> <li>• <a href="#">Faith in Older People</a></li> <li>• <a href="#">Humanists UK</a></li> <li>• <a href="#">National Secular Society</a></li> </ul>

PROTECTED CHARACTERISTIC (Equality Act 2010)	DEFINITION	RESOURCES
<b>SEX</b>	A man or a woman. Sex discrimination could be based on someone's actual or perceived sex, or on their connection to someone of a particular sex.	<ul style="list-style-type: none"> <li>• <a href="#"><u>National Alliance of Women's Organisations (NAWO)</u></a></li> <li>• <a href="#"><u>The Fawcett Society</u></a></li> <li>• <a href="#"><u>Womankind</u></a></li> <li>• <a href="#"><u>UK Feminista</u></a></li> <li>• <a href="#"><u>Centre for Women's Justice</u></a></li> <li>• <a href="#"><u>Forward</u></a></li> <li>• <a href="#"><u>End Violence Against Women</u></a></li> <li>• <a href="#"><u>Women's Aid</u></a></li> <li>• <a href="#"><u>Close the Gap</u></a></li> <li>• <a href="#"><u>ManKind Initiative</u></a></li> <li>• <a href="#"><u>Men and boys Coalition</u></a></li> <li>• <a href="#"><u>National Association of Women Pharmacists (NAWP), PDA</u></a></li> </ul>
<b>SEXUAL ORIENTATION</b>	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. The Equality Act 2010 says people must not be discriminated against because of their actual or perceived sexual orientation, or because of their connection to someone who has a particular sexual orientation.	<ul style="list-style-type: none"> <li>• <a href="#"><u>Stonewall</u></a></li> <li>• <a href="#"><u>LGBT Foundation</u></a></li> <li>• <a href="#"><u>The National LGBT Partnership</u></a></li> <li>• <a href="#"><u>LGBT Youth Scotland</u></a></li> <li>• <a href="#"><u>MindOut</u></a></li> <li>• <a href="#"><u>PDA LGBT+ (Lesbian, Gay, Bisexual and Transgender) Pharmacists' Network</u></a></li> <li>• <a href="#"><u>The Proud Trust</u></a></li> </ul>

# Consultation on the GPhC Equality guidance for pharmacies

## About the GPhC

### Who we are

We regulate pharmacists, pharmacy technicians and pharmacies in Great Britain.

We work to assure and improve standards of care for people using pharmacy services.

### What we do

Our role is to protect the public and give them assurance that they will receive safe and effective care when using pharmacy services.

We set standards for pharmacy professionals and pharmacies to enter and remain on our register.

We ask pharmacy professionals and pharmacies for evidence that they are continuing to meet our standards, and this includes inspecting pharmacies.

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.

Through our work we help to promote professionalism, support continuous improvement and assure the quality and safety of pharmacy.

### Foreword

At the GPhC we have worked hard to establish a culture where transparency, flexibility and collaboration is the norm. In our regulatory approach we focus on positive outcomes for patients and the public.

We have a legal duty, under the Equality Act, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between people from different groups, and foster good relations between people from different groups when carrying out all of our day-to-day functions and activities as a public body.

This applies to all of our work as a regulator and it's about integrating equality in everything we do. We want to support pharmacy owners to fulfil their legal and regulatory duties in relation to equality, as well as to provide a service which reflects good practice and is focused on continuous improvement.

Our newly published Delivering equality, improving diversity and fostering inclusion (EDI) strategy (**Our strategy for change 2021–26**) represents one of the steps we are taking to achieve this. It sets out our



intentions, and commitments, and includes our determination to use our standards to proactively help tackle discrimination and to make sure everyone can access person – centred care, fostering equality of health outcomes. One of the specific steps we committed to was to develop a comprehensive equality guidance for pharmacy owners.

Earlier this year we carried out a consultation on our EDI strategy, and were encouraged by the positive feedback we received. This included overwhelming support for the creation of equality guidance for pharmacy owners.

We heard about the importance of pharmacy owners creating open and inclusive environments and how equality guidance could help support this. We also heard that guidance could help equip pharmacy teams with the knowledge and confidence to tackle discrimination and that it should provide practical advice and guidance that could be applied in everyday work.

In developing the draft guidance, we have taken all of this feedback on board.

We now want to provide an opportunity for you to comment on our draft guidance. It has been created in collaboration with colleagues across the GPhC and several partner organisations, who commented on the aims, scope and content of the guidance.

We believe that this guidance will be a positive step in our efforts to tackle discrimination and foster equality of health outcomes in pharmacy and beyond. And we look forward to hearing your views.

***Nigel Clarke***

***Duncan Rudkin***

## **About the consultation**

This consultation provides background to our equality guidance and asks some important questions to sense-check our draft and to help us make it even more useful for pharmacy owners and pharmacy teams. We will share the paper with a range of stakeholders, including other health professional regulators, patient and professional representative organisations, employers, and education and training providers.

In addition, we will be carrying out targeted engagement with patients and service users, as well as with pharmacy professionals and owners of registered pharmacies.

Our consultation will remain open for 8 weeks – from 31 March until 26 May.

During this time, we welcome feedback from individuals and organisations. After we will publish a report summarising what we heard.

## **About our Equality guidance**

Our commitment to produce Equality guidance for pharmacies stems from our EDI strategy. It is an entirely new piece of guidance, which is designed to support pharmacy owners in understanding and meeting the **standards for registered pharmacies**. The guidance does not list the legal duties under the **Equality Act 2010** and the **Human Rights Act 1998** as all pharmacy owners must meet their legal responsibilities in addition to their regulatory responsibilities to meet our standards.

We are aware that those legal requirements, as well as our standards, pre-date the guidance, and pharmacy owners should already be aware of their obligations. However, we see this work as an important reminder that brings together the various elements they should be mindful of in their work.

Importantly, the guidance focuses the owners' attention not only on their duties towards patients and service users, but also towards their own staff.

The responsibility for following the guidance rests with the pharmacy owner, but we believe that the whole pharmacy team should read the guidance. We also believe that this guidance will be useful for all employers of pharmacy professionals, whether regulated by the GPhC or not. Education and training providers will also find it useful, since students and trainees will then be aware of their responsibilities with regards to equality, right from the start of their pharmacy career.

The Equality guidance (available in Appendix 1 below) is structured along the lines of the five principles in the standards for registered pharmacies, namely:

- **Principle 1:** The governance arrangements safeguard the health, safety and wellbeing of patients and the public.
- **Principle 2:** Staff are empowered and competent to safeguard the health, safety and wellbeing of patients and the public.
- **Principle 3:** The environment and condition of the premises from which pharmacy services are provided, and any associated premises, safeguard the health, safety and wellbeing of patients and the public.
- **Principle 4:** The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public.
- **Principle 5:** The equipment and facilities used in the provision of pharmacy services safeguard the health, safety and wellbeing of patients and the public.

It covers a variety of topics underneath each of the principles and introduces some of the tenets of the Equality Act that pharmacy owners must have regard to, including:

- **The nine protected characteristics** (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation)
- **The 'duty to make reasonable adjustments'** to the property from which services are provided, to meet the needs of people with disabilities (including patients, service users and employees)
- **The duty to remove discrimination, harassment and victimisation**

We are the regulator of registered pharmacies; the guidance reminds pharmacy owners of our expectations of them. This includes:

- The need to regularly assess the equality implications of their practices, policies, and procedures
- The need to create an open and inclusive culture to allow staff to feel empowered and able to comply with their own professional and legal obligations
- The need to encourage equality of opportunity and respect for diversity
- The need to nurture a fair and inclusive approach in their service provision and their relationships with other healthcare professionals and service providers
- The need to create a safe and suitable environment, which accounts for and meets the diverse needs of their local communities

Our Equality guidance also includes several examples, derived from the [GPhC Knowledge Hub](#) and inspections, which allow pharmacy owners to learn from others and continuously improve the services they provide to patients and the public.

## Responding to the consultation

### How we use your information

We will use your response to help us develop our work. We ask you to give us some background information about you and, if you respond on behalf of an organisation, your organisation. We use this to help us analyse the possible impact of our plans on different groups. We are committed to promoting equality, valuing diversity and being inclusive in all our work as a health professions regulator, and to making sure we meet our equality duties. There is an equality monitoring form at the end of the survey. You do not have to fill it in, but if you do, it will give us useful information to check that this happens.

### How we share your information

If you respond as a private individual, we will not use your name or publish your individual response. If you respond on behalf of an organisation, we will list your organisation's name and may publish your response in full unless you tell us not to. If you want any part of your response to stay confidential, you should explain why you believe the information you have given is confidential.

We may need to disclose information under the laws covering access to information (usually the Freedom of Information Act 2000). If you ask us to keep part or all of your response confidential, we will treat this request seriously and try to respect it but we cannot guarantee that confidentiality can be maintained in all circumstances.

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

### Your rights

Under data protection law, you may ask for a copy of your response or other information we hold about you, and you may also ask us to delete your response. For more information about your rights and who to contact please read our privacy policy on our website.

### How to respond

You can respond to this consultation by going to [www.pharmacyregulation.org/XXX](http://www.pharmacyregulation.org/XXX) and filling in the online questionnaire there.

We encourage respondents to use the online questionnaire. However, if you want to send a response by email, please write your response to the questions and send it to us at [consultations@pharmacyregulation.org](mailto:consultations@pharmacyregulation.org).

### Other formats

Please contact us at [communications@pharmacyregulation.org](mailto:communications@pharmacyregulation.org) if you would like a copy of the survey in another format (for example, in larger type or in a different language).

### Comments on the consultation process itself

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

[feedback@pharmacyregulation.org](mailto:feedback@pharmacyregulation.org)

or post them to us at:

Governance Team

General Pharmaceutical Council

25 Canada Square

London E14 5LQ

Please do not send responses to this address.

## Let us know your views

We welcome your views on our overall approach to the guidance, and in particular:

1. **Thinking about the structure and language of the guidance, do you think it is easy to understand?**

Yes/No/Don't know

**Please give comments explaining your answer**

Free text

2. **Thinking about the structure and language of the guidance, do you think it is easy to apply?**

Yes/No/Don't know

**Please give comments explaining your answer**

Free text

3. **Thinking about the areas covered in the guidance, do you think we have missed out anything important?**

Yes/No/Don't Know

**If yes, please describe the areas we have missed**

Free text

## Equality and impact questions

*We want to understand the impact our guidance may have on any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. These are:*

- *age*
- *disability*
- *gender reassignment*
- *marriage and civil partnership*
- *pregnancy and maternity*
- *race*
- *religion or belief*
- *sex*
- *sexual orientation*

**4. Do you think our guidance will have a positive or negative impact on individuals or groups who share any of the protected characteristics?**

*Matrix question - list all protected characteristics separately*

- Yes - positive impact
- Yes - negative impact
- Yes - positive and negative impact
- No impact
- Don't know

*We also want to understand the impact our guidance may have on any other individuals or groups (not related to protected characteristics), specifically:*

- *patients and the public*
- *pharmacy staff*
- *pharmacy owners*
- *any other individuals or groups*

**5. Do you think our guidance will have a positive or negative impact on any of these groups?**

*Matrix question - list patients and the public, pharmacy owners, pharmacy staff separately*

- Yes - positive impact
- Yes - negative impact
- Yes - positive and negative impact
- No impact
- Don't know

**Please give comments explaining your answer to the two impact questions above. Please describe the individuals or groups concerned and the impact you think our guidance would have.**

Free text

You can respond to this consultation by going to [www.pharmacyregulation.org/XXX](http://www.pharmacyregulation.org/XXX) and filling in the online questionnaire there.

This section will form not form part of the consultation but will be used to build the consultation

## Background questions

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

### Are you responding:

as an individual

on behalf of an organisation

## Section A: Responding as an individual

### Please tell us your:

first name:

surname:

email:

### Where do you live?

England

Scotland

Wales

Northern Ireland

Other

If you selected 'other', please say where:

### Are you responding as:

a pharmacist?

a pharmacy technician?

a member of the public?

other?

If you selected 'other', please explain:

Free text box

## Sector

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

Community pharmacy (including online)

Hospital pharmacy

Prison pharmacy

GP practice

Care home

Primary care organisation

Pharmaceutical industry

Research, education or training

Other

**If you selected 'other', please say what area you mainly work in:**

Free text box

## Size of community pharmacy

**Which of the following best describes the community pharmacy you work in (or own)? \***

Independent pharmacy (1 pharmacy)

Independent pharmacy chain (2-5 pharmacies)

Small multiple pharmacy chain (6-25 pharmacies)

Medium multiple pharmacy chain (26-100 pharmacies)

Large multiple pharmacy chain (Over 100 pharmacies)

Online- only pharmacy

## Section B: Responding on behalf of an organisation

**Do you want any part of your response to stay confidential? Important: we cannot guarantee that we can maintain confidentiality in all circumstances.**

Yes

No

**Please explain which parts you would like to keep confidential and why the information you have given is confidential.**

Free text box

**Please tell us your:**

first name:

surname:

job title:

organisation:

address:

email:

### Type of organisation

**Please choose the option below which best describes your organisation.**

Organisation representing patients or the public

Organisation representing pharmacy professionals or the pharmacy sector

Registered pharmacy

NHS organisation or group

Research, education or training organisation

Government department or organisation

Regulatory body

Other

**If you selected 'other', please specify say what type of organisation you work for:**

Free text

### Type of registered pharmacy

**Which of the following best describes the registered pharmacy you represent?**

Independent community pharmacy (1 pharmacy)

Independent community pharmacy chain (2-5 pharmacies)

Small multiple community pharmacy chain (6-25 pharmacies)

Medium multiple community pharmacy chain (26-100 pharmacies)

Large multiple community pharmacy chain (Over 100 pharmacies)

Online- only pharmacy

Hospital pharmacy

Prison pharmacy

Other

**If you selected 'other', please describe your pharmacy:**

Free text



We welcome your views on our overall approach to the guidance, and in particular:

6. **Thinking about the structure and language of the guidance, do you think it is easy to understand?**

Yes/No/Don't know

**Please give comments explaining your answer**

Free text

7. **Thinking about the structure and language of the guidance, do you think it is easy to apply?**

Yes/No/Don't know

**Please give comments explaining your answer**

Free text

8. **Thinking about the areas covered in the guidance, do you think we have missed out anything important?**

Yes/No/Don't Know

**If yes, please describe the areas we have missed**

Free text

## Equality and impact questions

*We want to understand the impact our guidance may have on any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. These are:*

- *age*
- *disability*
- *gender reassignment*
- *marriage and civil partnership*
- *pregnancy and maternity*
- *race*
- *religion or belief*
- *sex*
- *sexual orientation*

9. **Do you think our guidance will have a positive or negative impact on individuals or groups who share any of the protected characteristics?**

**Matrix question - list all protected characteristics separately**

Yes - positive impact

Yes - negative impact

Yes - positive and negative impact

No impact

Don't know

We also want to understand the impact our guidance may have on any other individuals or groups (not related to protected characteristics), specifically:

- patients and the public
- pharmacy staff
- pharmacy owners
- any other individuals or groups

**10. Do you think our guidance will have a positive or negative impact on any of these groups?**

*Matrix question - list patients and the public, pharmacy owners, pharmacy staff separately*

- Yes - positive impact
- Yes - negative impact
- Yes - positive and negative impact
- No impact
- Don't know

**Please give comments explaining your answer to the two impact questions above. Please describe the individuals or groups concerned and the impact you think our guidance would have.**

Free text

## Equality monitoring

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

We want to make sure everyone has an opportunity to respond to this consultation on our equality guidance. This equality monitoring form will give us useful information to check that this happens.

Your answers will not be linked to your consultation responses. You do not have to answer these questions if you would prefer not to.

### What is your sex?

Please tick one box

- Male
- Female
- Other
- Prefer not to say

### What is your sexual orientation?

Please tick one box

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

**Does your gender identity match your sex as registered at birth?**

Please tick one box

- Yes
- No
- Prefer not to say

**Do you consider yourself disabled?**

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

Please tick one box.

- Yes
- No
- Prefer not to say

**What is your age group?**

Please tick one box

- 16 – 24 years
- 25 – 34 years
- 35 – 44 years
- 45 – 54 years
- 55 – 64 years
- 65+ years
- Prefer not to say

**What is your race/ethnicity?**

Choose the option that best describes your ethnic group/cultural background. Please tick one box.

**White**

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

**Black or Black British**

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

**Mixed**

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

**Asian or Asian British**

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Other Asian background (please fill in the box at the end of this section)

**Arab**

- Arab

**Other**

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

**What is your religion?**

Please tick one box

- Buddhist
- Christian
- Hindu

- Jewish
- Muslim
- Sikh
- None
- Other (please give more information in the box below)
- Prefer not to say

## Appendix 1

# DRAFT: Equality guidance for pharmacies

Add guidance

# Post-registration assurance of practice

## Meeting paper for Council on 10 March 2022

Public business

### Purpose

To update Council on the outcome of the stakeholder meeting on 27 January and to agree how the work is taken forward.

### Recommendations

Council is asked to:

- Note the principles underpinning the work
- Note the direction of travel for governance of the work

## 1. Introduction

- 1.1 On 9 December Council agreed that the GPhC should convene and lead a new group, involving all the key stakeholders, focused on assurance of practice post-registration. This followed a report from a short-life working group, chaired by Aamer Safdar and consisting of five Council members alongside GPhC staff. This group was initially created to consider assurance of post-registration education and training. It developed to consider assurance of post-registration practice overall in order to give patients and the public assurance that pharmacy professionals and services are safe and effective.
- 1.2 As an initial step, we convened a meeting on 27 January, co-hosted with the Pharmaceutical Society of Northern Ireland and chaired by Nigel Clarke, which brought together a range of stakeholders, including the Chief Pharmaceutical Officers, employers, professional bodies, schools of pharmacy, statutory education bodies and commissioners of services from across the UK. The session involved a discussion on the principles underpinning the work and the most effective way to govern the work, ensuring wide stakeholder input while recognising the need for clear decision-making and development of the work at pace.

## 2. Principles underpinning the work

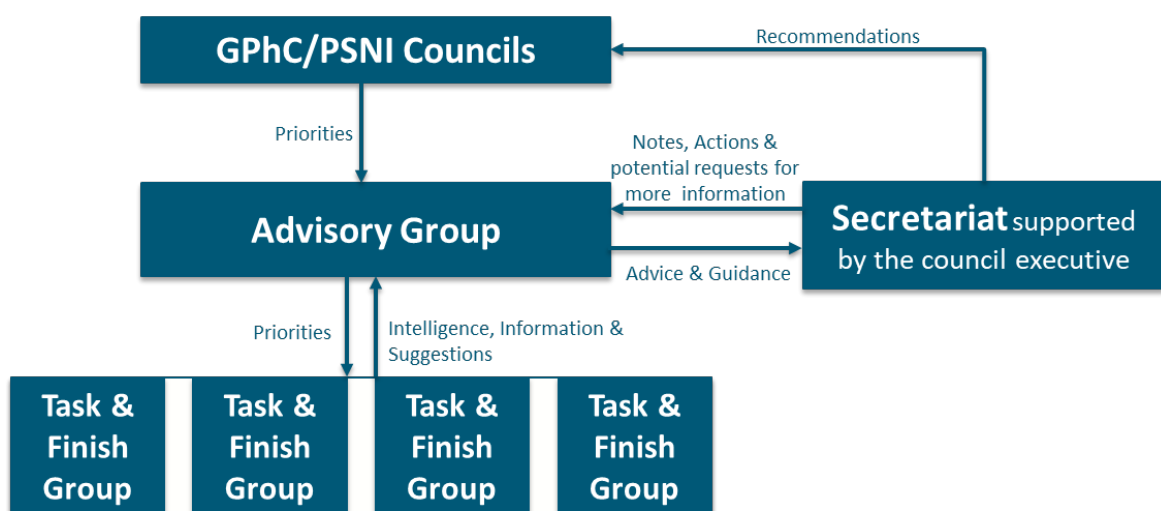
- 2.1 Based on the work undertaken by the short-life working group, we identified the following principles which were broadly welcomed and agreed by the stakeholder group.

- We must focus on protection of the public and patient safety, as our priority, to underpin all our work
- The level and type of assurance must be proportionate to the risk to public protection and patient safety
- We must use a range of the best available insights and intelligence but predominantly evidence to inform our recommendations
- We must take account of the thoughts and opinions of patients and the public to help identify priorities and the level and type of assurance
- We must identify the most appropriate organisation(s) to take responsibility for particular types of assurance
- We must determine appropriate recommendations, taking into account the context and **changes in healthcare** both now and in the future, to deliver effective and efficient outcomes.

There was some discussion on the need to ensure that the principles explicitly reflected the rapidly evolving changes to healthcare. With that in mind, we have suggested one amendment highlighted in bold above which replaces the previous and less specific “issues presented”.

### 3. Governance of the work

3.1 We envisage this work continuing over the longer-term so that there is an ongoing mechanism to provide assurance of practice as healthcare develops. We are working through the precise governance of the work to ensure there is a clear rationale which commands the confidence of Council and of stakeholders. The below diagram sets out a visual depiction of our current thinking and further details of how we see this working in practice are set also:



- **The role of Councils:** To decide whether they are satisfied that the necessary quality control, quality management and quality assurance mechanisms for post-registration assurance of practice are in place; and whether any additional assurance is required,



informed by the advice of the Advisory Group and recommendations of the secretariat/executive function.

- **The secretariat/executive function:** To assess and synthesise views from the Advisory Group in order to prepare recommendations for the Councils. This ensures that the content of the Advisory Group discussions is presented formally to Councils and that there is a clear record of decisions taken and commissioning of further work. This function would also provide secretariat support for the Advisory Group and task and finish groups
- **The role of the Advisory Group:** To commission work from task and finish groups and prepare advice for Councils on levels of assurance and any gaps in assurance. Representation on the Advisory Group would cover the four countries of the UK and the five principal levers of assurance: statutory regulation; professional frameworks, commissioning of services, employment; and education and training. This will ensure the appropriate range of knowledge so that Council receives well-rounded advice on the different assurance mechanisms and potential gaps or opportunities to strengthen assurance. We would propose that only one senior member of each organisation attends the Group to ensure numbers are manageable and at the appropriate level.
- **The role of the task and finish groups:** To undertake specific pieces of work which have been commissioned by the Advisory Group. The members of these groups would largely be drawn from the organisations represented on the Advisory Group and could draw in additional expertise where required. The work to be done by these groups would need to be identified by the Advisory Group and we would envisage one focusing on mapping the current landscape to identify the existing and planned assurance mechanisms across countries and sectors.

3.2 We will continue to work through the detail of this, engaging with the members of our existing Council short-life working group. The next stages of work will include considering appropriate chairing of the Advisory Group and drafting terms of reference prior to issuing invitations to stakeholders to attend the initial meeting of the Advisory Group. We will also keep working with PSNI to align our thinking on policy and governance arrangements.

#### 4. Equality and diversity implications

4.1 The Advisory Group will contain representation from the four countries of the UK and will encompass both pharmacists and pharmacy technicians. It will be essential for the EDI implications of recommendations for any additional assurance mechanisms to be fully considered as part of the decision-making process.

#### 5. Communications

5.1 We issued a statement on 28 January informing people about the stakeholder discussions to establish a formal group focused on the assurance of post-registration practice of pharmacists and pharmacy technicians. We will continue to communicate directly with stakeholders and envisage regular updates following meetings of the Advisory Group.

#### 6. Resource implications

6.1 An additional resource has been factored into our budget for 2022/23. We will identify any further implications as the work develops.

## **7. Risk implications**

7.1 The purpose of this work is to mitigate the risk that, as pharmacy continues to develop rapidly, roles and activities are undertaken for which the right level of skills and knowledge have not been assured. In terms of taking the work forward, setting out the principles underpinning the work and a clear governance structure mitigates the risk of insufficient buy-in and understanding of the work.

## **8. Monitoring and review**

8.1 Regular updates will be provided to Council as part of the ongoing work and the arrangements outlined above are likely to evolve, subject to Council's steer, as we progress. We would expect any specific recommendation for additional assurance mechanisms to contain specific detail of how the impact of changes are monitored and evaluated.

## **Recommendations**

Council is asked to:

- Note the principles underpinning the work
- Note the direction of travel for governance of the work

Mark Voce, Director of Education and Standards  
General Pharmaceutical Council

02/03/22

# Engagement and communications report

## Meeting paper for Council meeting on 10 March 2022

### Public business

#### Purpose

To update the Council on engagement and communications with stakeholders through a quarterly report.

#### Recommendations

The Council is asked to note this paper.

#### 1. Introduction

1.1 This report outlines key communications and engagement activities since November 2021 and highlights upcoming events and activities.

#### 2. Publication of our new strategy to deliver equality, improve diversity and foster inclusion

2.1 On 10 November 2021, we published our new strategy: **Delivering equality, improving diversity and fostering inclusion: Our strategy for change 2021-2026.**

2.2 We promoted the new strategy through a press release to the pharmacy trade media, social media activity and targeted emails to key stakeholder organisations and respondents to the consultation.

#### 3. Consultation on holding remote hearings in the future

3.1 Between 16 November 2021 and 8 February 2022, we held a 12-week consultation to seek feedback on a proposed permanent change to our procedural rules, to give us the express legal power to conduct hearings and meetings by teleconference or video-link.

3.2 We promoted this consultation through targeted emails to stakeholders, a press release and social media. We also held a survey with our online patient panel, to make sure we heard the views of patients and the public during the consultation.

3.3 We received a total of 474 responses to the consultation and 148 responses to the survey with the online public panel.

#### 4. Appointment of our new Chair

4.1 We **announced the appointment of Gisela Abbam as our new Chair** in February through a press release, an article in Regulate, our e-newsletter to our registrants, targeted emails to stakeholders and social media activity.

4.2 Our Twitter post about the Chair appointment was the most seen Twitter post in this period with 20,000 impressions (the number of times people saw the tweet including via retweets).

#### 5. Assurance of post-registration practice of pharmacists and pharmacy technicians

5.1 On 27 January 2022, we brought together key stakeholders for an online meeting, jointly hosted with the Pharmaceutical Society of Northern Ireland (PSNI), to discuss establishing a formal group focused on the assurance of post-registration practice of pharmacists and pharmacy technicians.

5.2 This followed the Council's decision to establish the group after considering the recommendations from a short-life working group chaired by Council member Aamer Safdar on the potential leadership and quality assurance role of the GPhC in post-registration education and training for pharmacists and pharmacy technicians.

5.3 We **issued a press release jointly with the PSNI** to highlight the meeting and to outline the next steps for establishing the group.

#### 6. COVID-19 vaccinations for pharmacy professionals

6.1 Since COVID-19 vaccinations became available, we have strongly reminded all pharmacists and pharmacy technicians across Great Britain that they should be vaccinated at the earliest opportunity, unless they are medically exempt.

6.2 The UK government announced on 31 January 2022 that it would not proceed with requiring vaccination as a condition of deployment for health and care staff providing CQC-regulated activities in England.

6.3 Following the Secretary of State's announcement, **we issued a statement** which reiterated our position on COVID-19 vaccination for pharmacy professionals in Great Britain.

6.4 We shared this statement with pharmacy professionals and other key audience through our e-newsletter, Regulate, as well as through our website, social media channels, the pharmacy trade press and direct communications with stakeholders.

6.5 Our Twitter post highlighting our statement had the highest engagement rate of the period at 26%. (The engagement rate is the number of engagements such as clicks, retweets and likes, as a percentage of impressions or number of times people have seen the tweet).

## 7. Revalidation requirements until 31 May 2022

- 7.1 In December, we **announced that we were extending changes to our revalidation requirements** in recognition of the continuing pressures linked to the COVID-19 pandemic that pharmacy professionals were facing over the winter period.
- 7.2 We explained in our communications that pharmacists and pharmacy technicians who have registration renewal deadlines on or before 31 May 2022 would only need to submit a reflective account for revalidation and will not need to submit the other five revalidation records.
- 7.3 We contacted all pharmacy professionals due to renew on or before 31 May 2022 directly via email to let them know about this decision and what it meant for them.
- 7.4 We also worked with stakeholders and the pharmacy media to publicise this decision and spread the word via our social media channels.

## 8. Statement on abuse and violence against pharmacy professionals

- 8.1 In December 2021, we issued **a statement from Duncan Rudkin** in response to worrying reports of pharmacy professionals and pharmacy teams working in a range of settings experiencing abuse and even violence from members of the public.
- 8.2 The statement emphasised that any abuse of pharmacy staff is completely unacceptable and robust action should be quickly taken in response to any incidents, including by law enforcement.
- 8.3 In the statement, we urged the public to treat pharmacy staff with respect at all times, and to follow the requirements on wearing face masks, as well as any social distancing measures in place within a pharmacy. We also signposted pharmacy teams to useful resources they could use in the pharmacy to encourage patients and the public to treat staff with respect.

## 9. Thank you message to pharmacy staff

- 9.1 On 22 December 2022, we **published a message to pharmacy teams and owners** which thanked them for their hard work at a particularly challenging time.
- 9.2 In the message, we explained what we were doing to support pharmacy professionals and pharmacies, including pausing inspections and changing our revalidation requirements, to reduce the pressures on pharmacy staff.
- 9.3 We also signposted pharmacy teams and owners to key resources to help them provide safe and effective care to patients and the public, including examples of notable practice on our knowledge hub.

## 10. Closure of the provisional register

- 10.1 The provisional register was put in place in July 2020 in response to the impact of the COVID-19 pandemic on pre-registration training, including the postponement of the registration assessment.

- 10.2 The register was closed on 31 January 2022. This meant that people still on the register were no longer able to practise as provisionally-registered pharmacists after this date.
- 10.3 We implemented an extensive programme of communications to provisionally-registered pharmacists to make them aware that the provisional register was closing and explain their options.
- 10.4 We also communicated directly with employers and training leads and worked closely with key stakeholder organisations to share key messages through their networks, as well as providing information via our website and social media channels.
- 10.5 The vast majority of provisionally-registered pharmacists successfully applied to join the pharmacist register before the provisional register closed.
- 10.6 Ahead of the provisional register closing, **we issued a statement** to thank provisionally-registered pharmacists, and all those involved in supporting them, and to recognise the significant contribution they have made to health services during the COVID-19 pandemic.

## 11. Registration assessment

- 11.1 On 17 December 2021, we **announced the results for the first common registration assessment** held jointly with the Pharmaceutical Society of Northern Ireland (PSNI).
- 11.2 We worked closely with the Pharmaceutical Society NI on the communications to candidates for the sitting, and for issuing the results.
- 11.3 In January, we announced that we will be working with a new provider, BTL Group Ltd, to run the common registration assessment sittings.
- 11.4 Shortly after that announcement, we contacted all potential candidates to let them know that the next registration assessment would be held on 29 June 2022 and to provide further details about the sitting.
- 11.5 We are continuing to send regular updates to potential candidates about the assessment, including about how to request reasonable adjustments and when they can apply for the June sitting.

## 12. Professional Standards Authority performance review 2020/21

- 12.1 We **issued a statement** in response to the Professional Standards Authority's publication of our performance review for 2020/21.
- 12.2 In our statement, we highlighted that it is a key priority for us to make improvements in our fitness to practise processes and that we have now managed to complete almost all of the planned improvement actions.

## 13. Recent events and meetings

- 13.1 Please see appendix 1 for a list of key events and meetings that have taken place since November 2021.
- 13.2 Council members are reminded to liaise with the office before accepting external invitations to speak on behalf of the GPhC in order to minimise overlap and ensure they have the most

up-to-date supporting material.

## 14. Upcoming events and activities

Please contact Laura Turton, Stakeholder Engagement Manager, at [laura.turton@pharmacyregulation.org](mailto:laura.turton@pharmacyregulation.org) if you would like to attend any of these events:

### **British Pharmaceutical Students' Association annual conference, Aston University, 06/04/22**

We will have an exhibition stand at this event.

### **University of Manchester, 27/04/22**

Lisa Gilbert (Pre-registration Training Manager) presentation on 'preparing for your foundation training year'. Event 13:00-16:00.

### **Clinical Pharmacy Congress, ExCel London, 13/05/22**

Claire Bryce-Smith (Director for Insight, Inspection and Intelligence) presentation on online pharmacy and risk management of clinical services from 10:45-11:15

## Consultations

14.1 Please see appendix 2 for the grid of active and new external consultations to which we have considered responding.

## 15. Equality and diversity implications

- 15.1 As highlighted above, in this period we have published and promoted our new strategy to deliver equality, improve diversity and foster inclusion.
- 15.2 We have also begun to undertake communications activity to support external initiatives that link with the strategic aims and objectives of this strategy.
- 15.3 This has included promoting the PANORAMIC study; a UK-wide clinical study looking at new antiviral treatments for COVID-19, to help make sure everyone has the opportunity to take part in the trial.
- 15.4 Through an article in Regulate and our social media channels, we highlighted how pharmacy teams can play an important role in raising awareness about the PANORAMIC study and supporting greater recruitment of volunteers from underserved and diverse backgrounds, to ensure the study is as inclusive as possible.

## 16. Recommendations

The Council is asked to note this paper.

Rachael Gould, Head of Communications  
General Pharmaceutical Council

02 March 2022

## Appendix 1

### Events from 11 November 2021 – 9 March 2022

#### **Rotherham Local Pharmaceutical Committee, 11/11/21**

Shelley Edmonds (Inspector) presentation on GPhC update.

#### **Sigma webinar, 16/11/21**

Duncan Rudkin (Chief Executive) participated in panel discussion on hub and spoke.

#### **Nottinghamshire Local Pharmaceutical Committee, 17/11/21**

Shelley Edmonds (Inspector) presentation on GPhC update.

#### **Superdrug Foundation Trainees, 25/11/21**

Lisa Gilbert (Pre-registration Training Manager) and Eilean Robson (Inspector) presentation on reforms to initial education and training for pharmacists.

#### **Controlled Drug Liaison Officers, 25/11/21**

Akhtar Malik (Inspector) presentation on GPhC update.

#### **Doncaster Local Pharmaceutical Committee, 10/01/22**

Shelley Edmonds (Inspector) presentation on GPhC update.

#### **Association of Independent Multiple Pharmacies member and partner event, 27/01/22**

Nigel Clarke (Chair) spoke on GPhC priorities for 2022.

#### **Pharmacists' Defence Association, 01/02/22**

Laura Fraser (Director for Scotland) and Sarah Purdy (Pre-registration Training Manager) presentation on reforms to initial education and training for pharmacists.

#### **East Sussex Local Pharmaceutical Committee, 10/02/22**

David Clarke (Inspector) presentation on GPhC update.

### Meetings from 11 November 2021

Listed below is a non-exhaustive selection of significant meetings since the last engagement and communications report to Council.

Initials are as follows: Nigel Clarke (NC), Duncan Rudkin (DR), Carole Auchterlonie (CA), Claire Bryce-Smith (CBS), Laura Fraser (LF), Liam Anstey (LA), Mark Voce (MV)

#### **1. Chair (Nigel Clarke):**

- Meeting with Dame Professor Carrie MacEwen, Acting Chair, General Medical Council
- National Pharmacy Association Centenary dinner
- Peter Noyce fifth Memorial Lecture



## 2. Staff:

- Meeting with Company Chemists' Association (CBS)
- Meeting with Avicenna (CBS)
- Meeting with NHS Highland Pharmacy Education & Research Centre (LF)
- Meeting with Association of Independent Multiple Pharmacies (CBS)
- National Pharmacy Association Centenary dinner (DR)
- National Overprescribing Review Implementation - analytics subgroup (CBS)
- Meeting with Royal Pharmaceutical Society (CBS)
- Meeting with Healthcare Improvement Scotland (LF)
- Achieving Excellence in Pharmaceutical Care Advisory Group meeting (LF)
- Meeting with NHS Education for Scotland (DR, MV, LF)
- Meeting with Community Pharmacy Scotland (LF)
- Welsh Government healthcare summit (LA)
- Meeting with Welsh NHS Confederation Health and Wellbeing Alliance (LA)
- Meeting with National Pharmacy Association (DR)
- Meeting with European Partnership for Supervisory Organisations in Health Services and Social Care (CBS)
- Meeting with Welsh Government and Royal Pharmaceutical Society Wales (LA)
- Meeting with University of Leicester (MV)
- Meeting with National Pharmacy Association (CBS)
- Professional Regulators meeting (LF)
- Meeting with Chief Pharmaceutical Officer for England (DR)
- Meeting with Health Education and Improvement Wales (LA)
- Meeting with Royal Pharmaceutical Society Scotland (LF)
- Meeting with Department of Health and Social Care (DR)
- Wales Government Duty of Candour stakeholder workshop (LA)
- Meeting with NHS Greater Glasgow and Clyde (LF)
- Meeting with Health Education England and NHS England & NHS Improvement (MV)
- Meeting with Royal Pharmaceutical Society (MV)
- QIPP quarterly meeting (LF)
- Consultant Pharmacists Working Group (LF)
- Chief Executives of Regulatory Bodies (CEORB) meeting (DR)
- Meeting with Pharmacists' Defence Association (LF, LA)

- Meeting with Lloyds Pharmacy (CBS)
- Meeting with Nursing and Midwifery Council (MV)
- Regulators' Network meeting (DR)
- Meeting with Healthcare Improvement Scotland (LF)
- Pharmacy Technicians Education & Training Strategic Group meeting (LF)
- Meeting with NHS Lothian (LF)
- Meeting with Pharmacy Schools Council (MV)
- Clinical Academic Careers Short Life Working Group (MV)
- Meeting with NHS Highland (LF)
- Meeting with NHS Ayrshire & Arran (LF)
- Non-medical Prescribing Competency Assurance Short-Life Working Group (LA)
- Meeting with University of Central Lancashire (MV)
- Meeting with University of Leicester (MV)
- Primary Care Quality Board meeting (CBS)
- Speaking Up Partnership Group meeting (CBS)
- Foundation Training Year Working Group (LF)
- National Overprescribing Review Implementation Oversight Group (DR)
- Meeting with Community Pharmacy Wales (LA)
- Meeting with regulators in Wales (LA)
- Short life working group on Promoting Pharmacy Careers in Scotland (LF)
- Meeting with Scottish government (LF)
- Meeting with Pharmacist Defence Association Scotland (LF)
- Meeting with Company Chemists Association (DR)
- Chiropractic, Optical, Pharmacy, Osteopathic and Dental regulatory bodies meeting (DR)
- Meeting with Pharmaceutical Services Negotiating Committee (DR)
- Chief Executive's Steering Group meeting (DR)

## Appendix 2

### Active and new consultations

The table below lists all the consultations we have considered and provided responses to. Consultations we have responded to are listed first; those we have considered but not responded to appear next on the list.

Please note that we do not normally respond to consultations from other independent statutory health professional regulators. These are reviewed, shared and considered, but usually it is not appropriate or necessary for the GPhC to respond.

**Table 1: Active and new consultations**

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<a href="#"><u>Consultation on mandatory vaccination for frontline health and care staff</u></a>	DHSC	The government is seeking views on plans for staff in health and care settings in England to be required to have COVID-19 and flu vaccines to protect vulnerable people.	22/10/2021	Responded to	Formal written response	AA (Standards)	We are submitting a response to this consultation because a number of our registrants work in areas regulated by the CQC and will therefore be affected if vaccinations became mandatory.	<a href="https://www.pharmacyregulation.org/sites/default/files/document/gphc-consultation-response-vaccination-condition-deployment-nov-2021.pdf"><u>https://www.pharmacyregulation.org/sites/default/files/document/gphc-consultation-response-vaccination-condition-deployment-nov-2021.pdf</u></a>

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>A National Care Service for Scotland: consultation</u></b>	<b>Scottish government</b>	RPS Scotland is holding a focus group to hear members' views on the Scottish Government's consultation on a new National Care Service.	02/11/2021	Responded to	Formal written response	LF (Scotland)	The proposals make fundamental changes to who is considered to work under the national health or national care service and governance as well as collaboration and communication across the interfaces needs scrutiny to ensure patient safety. This could impact our FtP and assurance functions.	
<b><u>The future of pharmacy inquiry</u></b>	<b>The All-Party Pharmacy Group</b>	Parliamentarians from the All-Party Pharmacy Group have launched an inquiry and call for written evidence into the future of the pharmacy sector in the wake of the COVID-19 pandemic. The pharmacy sector and wider healthcare stakeholders are being encouraged to share their views to inform the development of a manifesto which aims to unlock the potential of	01/11/2021	Responded to	Formal written response	AA (Standards)	Given the nature and scope of this inquiry, it was felt that it was important for us to respond, providing an update on relevant GPhC workstreams, as well as good practice case studies we have identified through our inspection activity.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		pharmacy and further improve patient outcomes.						
<b><u>Extending free PPE to the health and care sector</u></b>	DHSC	DHSC is seeking views on whether it should extend the provision of free personal protective equipment (PPE) to the health and care sector after 31 March 2022.	31/10/2021	Responded to	Formal written response	AA (Standards)	We have responded to this consultation to support our registrants.	
<b><u>Proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill</u></b>	Scottish Government	This is a proposal for a Member's Bill to enable competent adults who are terminally ill to be provided at their request with assistance to end their life.	22/12/2021	Responded to	Formal written response	LF (Scotland)	We have responded to this consultation to ensure the right safeguards are considered and put in place to protect registrants who may be implicated in this	
<b><u>Original pack dispensing and supply of medicines containing sodium valproate</u></b>	DHSC	This consultation seeks views and comments on proposals to update the requirements in legislation to enable original pack dispensing (OPD) for pharmacists and to introduce requirements to ensure	13/12/2021	Reviewed but not responding	No response	TD (Standards)	Whilst we couldn't answer the questions directly, we used the opportunity to highlight the importance of patient information leaflets.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		medicines that contain sodium valproate are always dispensed in the original manufacturer's packaging.						
<b><u>Banning conversion therapy</u></b>	<b>Government Equalities Office</b>	The government will introduce a legislative ban on the practice of so-called conversion therapy. This consultation seeks views on proposals on how the government plan to ban these practices, which particularly affect LGBT people.	10/12/2021	Responded to	Formal written response	AS (EDI)	We have responded to this consultation to welcome and strongly support the Government's commitment to introduce a legislative ban on the coercive and abhorrent practice of conversion therapy in England and Wales, in line with our recently launched EDI strategy	<a href="https://www.pharmacyregulation.org/sites/default/files/document/general-pharmaceutical-council-response-to-the-uk-equalities-office-consultation-on-banning-conversion-therapy-january-2022.pdf">https://www.pharmacyregulation.org/sites/default/files/document/general-pharmaceutical-council-response-to-the-uk-equalities-office-consultation-on-banning-conversion-therapy-january-2022.pdf</a>
<b><u>Refining our regulator reviews: follow-up consultation</u></b>	<b>PSA</b>	In this second consultation on regulatory reviews, the PSA are seeking feedback on three key areas:	21/12/2021	Responded to	Formal written response	LMC (Executive Office)	We have provided further comment to the proposals, in line with the comments we provided to the	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		<ul style="list-style-type: none"> <li>• Moving from an annual process to one where they look in detail periodically, with ongoing monitoring in between to maintain their oversight</li> <li>• Their proposals for setting this period as a three-year cycle</li> <li>• The factors they will consider when determining whether they need to look in more depth at a regulator's performance.</li> </ul>					previous consultation on this topic.	
<b><u>NHS Scotland climate emergency and sustainability strategy 2022 to 2026 - draft: consultation</u></b>	<b>Scottish government</b>	The Scottish Government and NHS Assure are consulting on their draft Climate Emergency and Sustainability Strategy 2022 to 2026 for NHS Scotland.	10/02/2022	Reviewed but not responding	No response	LF (Scotland)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<a href="#"><u>Consultation on OfS strategy for 2022-25</u></a>	OfS	The OfS are seeking views on their proposed strategy for 2022-25. The consultation proposes a plan of action that will guide their activities as a regulator over the next three years. It will make sure they are targeted, sequence thier work effectively, and are able to achieve thier aims and make best use of the resources they have available.	06/01/2022	Reviewed but not responding	No response	DD (Education)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<a href="#"><u>Hospital discharge and its impact on patient flow through hospitals</u></a>	Welsh Parliament	During the Sixth Senedd, the Health and Social Care Committee plans to explore how patient flow through hospitals can be improved. The first part of this work is a short inquiry focusing on hospital discharge and its impact on patient flow through hospitals.	07/01/2022	Reviewed but not responding	No response	LA (Wales)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	



Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
Input on introducing a list of healthcare professionals whom a worker can make a disclosure to	DHSC	Following a consultation in 2020 on the use of workplace confidentiality clauses (or Non-Disclosure Agreements), the Department of Business, Enterprise and Industrial Strategy are looking to introduce legislation which ensures that a confidentiality clause cannot prevent an individual disclosing to the police, regulated health and care professionals or legal professionals.	15/12/2021	Responded to	Informal response (letter, email, other engagement)	LMC (Executive Office)	As this was a direct request, we have provided the DHSC with feedback for the Department of Business, Enterprise and Industrial Strategy on this legislative proposal.	
<b><u>Workforce: recruitment, training and retention in health and social care</u></b>	Health and Social Care Committee	Inquiry into reasons behind staff leaving the health and social care sectors and how to tackle them will be examined in a new inquiry. Workforce recruitment and training will also be explored.	19/01/2022	Reviewed but not responding	No response	DD (Education)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>The impact of body image on physical and mental health</u></b>	<b>Health and Social Care Committee</b>	MPs will examine the relationship between people's perception of their body image and their physical and mental health. They will consider how far people's perception of body image can hinder access to NHS services and whether NHS training and Government messaging should be altered.	22/01/2022	Reviewed but not responding	No response	AA (Standards)	Whilst we touch on non-surgical cosmetic products in our online and prescribing guidance, commenting on this inquiry fall outside of our remit. However, we are following developments, as there might be relevant implications for our work.	
<b><u>Professional Qualifications Bill</u></b>	<b>Public Bills Committee - Scrutiny Unit</b>	The Public Bill Committee is now able to receive written evidence on the Professional Qualifications Bill. The Bill would set out a new system for how professional qualifications gained abroad are recognised in the UK. It would also seek to allow regulators in the UK and overseas to mutually recognise qualifications where	20/01/2022	Responded to	Formal written response	SG (Registration and International Policy)	We responded to this consultation as it directly impacts pharmacy professionals wishing to join our register from overseas.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		they cannot do that now.						
<b><u>Healthcare regulation: deciding when statutory regulation is appropriate</u></b>	DHSC	DHSC is seeking views on the criteria used to make decisions on which health and social care professions should be regulated.	31/03/2022	Responded to	Formal written response	LMC (Executive Office)	We have responded to this consultation as it directly impacts our role as professions regulator	
<b><u>Consultation on public interest guidance for suicide pact and 'mercy killing' type cases</u></b>	CPS	The CPS is conducting a public consultation on a proposed revision to its legal guidance on Homicide: Murder and Manslaughter. The purpose of the consultation is to provide interested persons with an opportunity to provide comments and to ensure the final version of the guidance is informed by as wide a range of views as possible.	09/04/2022	Reviewed but not responding	No response	SD (Legal)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>Alternative pathways into primary care (in depth consultation for medical professionals or organisations)</u></b>	<b>Scottish Health, Social Care and Sport Committee</b>	The Health, Social Care and Sport Committee is undertaking an inquiry into how patients access primary care in Scotland. This inquiry intends to explore how alternative pathways are being accessed and used in primary care. It also seeks to identify key issues and opportunities for improvement.	22/02/2022	Reviewed but not responding	No response	LF (Scotland)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<b><u>Changes to the General Dental Council and the Nursing and Midwifery Council's international registration legislation</u></b>	<b>DHSC</b>	The Department of Health and Social Care, on behalf of the UK government and the devolved administrations, is seeking views on proposed changes to the GDC and the NMC international registration legislation. The aim is to provide these regulators with greater flexibility to amend their international registration processes	06/05/2022	Reviewed but not responding	No response	SG (Registration and International Policy)	We are in discussion with other health regulators and the DHSC about regulatory reform so have used the opportunity to input our views at those meetings. We are also going through our own regulatory reform process with DHSC. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		by removing prescriptive detail about how such processes should operate from legislation.						
<b><u>Revoking vaccination as a condition of deployment across all health and social care</u></b>	DHSC	Given the changes in clinical evidence, the government is revisiting the balance of risks and benefits that guided its original decisions to make coronavirus (COVID-19) vaccination a condition of deployment	16/02/2022	Responded to	Informal response (letter, email, other engagement)	AA (Standards)	We responded to this consultation to reiterate our previous feedback as a number of our registrants work in areas regulated by the CQC and will therefore be affected by this consultation's outcome.	
<b><u>Illegal practice strategy review</u></b>	GOC	GOCs illegal practice strategy and protocol were last reviewed in 2015. Their current approach is reactive to complaints being received. They believe they can better use their resource to develop a strategy that links more closely with their overarching public protection function and enhance sector and	19/01/2022	Reviewed but not responding	No response	Executive Office	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		public awareness of thier remit.						
<b><u>Consultation on OfS strategy for 2022-25</u></b>	<b>OfS</b>	The OfS are seeking views on their proposed strategy for 2022-25. The consultation proposes a plan of action that will guide their activities as a regulator over the next three years. It will make sure they are targeted, sequence thier work effectively, and are able to achieve thier aims and make best use of the resources they have available.	06/01/2022	Reviewed but not responding	No response	Education	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<b><u>Our Strategy – Your Views</u></b>	<b>HIW</b>	HIW are currently developing a new organisational strategy for the next three years and would like to hear the views of as many people as possible on	11/01/2022	Reviewed but not responding	No response	Wales	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		what their focus and priorities should be.						
<b><u>Adjunctive therapies, non-osteopathic treatments or other work undertaken by osteopaths: Draft guidance on the application of the Osteopathic Practice Standards</u></b>	GOsC	GOsC are inviting views on their draft guidance on non-osteopathic treatment or other work. This aims to explain the relationship between the Osteopathic Practice Standards (OPS) and the range and breadth of osteopathic practice, adjunctive therapies, and other forms of care and treatment provided by osteopaths, as well as non-osteopathic work.	11/04/2022	Reviewed but not responding	No response	Standards	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<b><u>Student outcomes and teaching excellence consultations</u></b>	OfS	The Office for Students are consulting on three new sets of proposals for the regulation of quality and standards in English higher education: Student	17/03/2022	Reviewed but not responding	No response	Education	We are not responding to this consultation. However, we are following developments, as there might be relevant	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		outcomes; The Teaching Excellence Framework; and Student outcome and experience data indicators					implications for our work.	



# Deputising arrangements for the Chair of Council

## Meeting paper for Council on 10 March 2022

Public

### Purpose

To note the deputising arrangements for the Chair of Council

### Recommendations

The Council is asked to note the arrangements for the deputy Chair, should the Chair be unavailable.

#### 1. Introduction

- 1.1 In February 2010 the Council agreed to establish a rota of Council members to deputise for the Chair if required. It was agreed that a rota was more appropriate than a formal election process, given that the need for a deputy would arise only if the Chair was absent or unable to perform his or her duties. This system would also avoid the impression that there was a 'Deputy Chair' with a different role and status from other Council members.
- 1.2 It was also agreed that a rotation every six months, agreed in advance, would allow arrangements to be made quickly should the Chair be unexpectedly absent.

#### 2. Deputising rota for 2022-23

- 2.1 The current rota expires at the end of March 2022. The new rota to cover the next twelve months is as follows (the rota for the last five years is included for reference):

*New rota:*

Name	Deputising start date	Deputising end date
Penny Mee-Bishop	1 April 2022	30 September 2022
Rima Makarem	1 October 2022	31 March 2023

*Current and previous rotas:*

Name	Deputising start date	Deputising end date
Neil Buckley	01 October 2021	31 March 2022
Ann Jacklin	01 April 2021	30 September 2021
Aamer Safdar	01 October 2020	31 March 2021
Elizabeth Mailey	01 April 2020	30 September 2020
Jayne Salt	01 October 2019	31 March 2020
Mark Hammond	01 April 2019	30 September 2019
Samantha Quaye	01 October 2018	31 March 2019
Joanne Kember	01 April 2018	30 Sep 2018
Mohammed Hussain	01 October 2017	31 March 2018
Arun Midha	01 April 2017	30 September 2017

### **3. Equality and diversity implications**

3.1 There are no specific equality and diversity implications.

### **4. Communications**

4.1 Council members and staff need a clear understanding of the arrangements for deputising for the Chair, if required. These will be communicated to staff via the intranet.

### **5. Resource implications**

5.1. These arrangements are to provide cover for single events over short periods of time and as such have no specific resource implications. Should the position of Chair become vacant for a longer period of time, other arrangements would need to be put in place.

### **6. Risk implications**

6.1 If the Council does not have a process in place for identifying a deputy in advance should the need arise, it runs the risk of having no leadership for a period of time should the Chair be absent without warning or the position of Chair become temporarily vacant for any reason. These arrangements mitigate that risk.

### **7. Monitoring and review**

7.1 The rota is considered annually.

### **8. Recommendations**

The Council is asked to note the arrangements for the deputy Chair, should the Chair be unavailable.

Janet Collins, Senior Governance Manager  
General Pharmaceutical Council

28 January 2022

## **Committee memberships 2022/23**

### **Meeting paper for Council on 10 March 2022**

Public

#### **Purpose**

To confirm the membership of the non-statutory committees for 2022/23

#### **Recommendations**

The Council is asked to approve the membership and chairs of the non-statutory committees as set out in section 2 below, with effect from 1 April 2022 to 31 March 2023.

##### **1. Introduction**

1.1 The membership of the Council's non-statutory committees (Audit and Risk; Finance and Planning; and Workforce) is reviewed every 12 months through an agreed process. Members are invited to express an interest in remaining on or joining a committee and the Chair takes soundings from colleagues before recommending members for appointment by Council.

##### **2. Appointments**

2.1 In 2019 and 2020 there were eight new members of Council who joined committees, meaning that there were significant changes to committee membership.

2.2 In 2021 there were no new appointments and no changes to committee membership were suggested, given the scale of the changes which had taken place the year before.

2.3 With the organisation facing significant changes in 2022/23 and the arrival of a new Chair of Council, it is proposed that we once again retain the existing membership of the committees as it will be important that business is conducted by members who are experienced in the work of their committee and that the Chair has the support of this experience.

2.4 In order to ensure that members were happy to continue to serve on their relevant committees, this suggestion was put to members, all of whom were in agreement. Some members have indicated that they may wish to change committees next year and these preferences have been noted. A call for expressions of interest in changing committees will be made to all members early in 2023, ensuring that all members have an opportunity to consider their position for 2023/24.

2.5 Council is therefore asked to confirm that the current memberships and chair positions held by Council members (set out below) will continue for a further 12 months, from 1 April 2022 to 31 March 2023.

- 2.6 For information, the external members of the Audit and Risk and Workforce Committees were all re-appointed in 2020 for a second term. The tenure of the external member of the Finance and Planning Committee expires later in 2022 and the committee will consider whether it wishes to offer a re-appointment or go out to recruit for a new external member.

#### **Audit and Risk Committee**

<b>Name</b>	<b>Notes</b>
Neil Buckley	Chair
Ann Jacklin	
Aamer Safdar	
Jayne Salt	
Yousaf Ahmad	
Helen Dearden	External member

#### **Finance and Planning Committee**

<b>Name</b>	<b>Notes</b>
Mark Hammond	Chair
Gisela Abbam	Replacing Nigel Clarke
Penny Hopkins	
Rima Makarem	
Rose Marie Parr	
Andrew McLaren	External member

#### **Workforce Committee**

<b>Name</b>	<b>Notes</b>
Elizabeth Mailey	Chair
Arun Midha	
Jo Kember	
Selina Ullah	
Rob Goward	External member
Janet Rubin	External member

### **3. Equality and diversity implications**

- 3.1 There are no specific equality and diversity implications. The recommendations take account of the desirability of committee members having a range of knowledge and experience to

allow the committees to discharge their functions effectively and the suggestion that membership does not change this year continues this.

#### **4. Communications**

4.1 The membership of the committees is published on the GPhC website, together with members' declarations of interest.

#### **5. Resource implications**

5.1 There are no resource implications associated with this paper. Council member remuneration and additional remuneration for Chairs is already included in the budget for 2022/23.

#### **6. Risk implications**

6.1 The appointment of members to these committees by Council is essential to enable them to discharge their responsibilities in relation to risk management, financial oversight and planning which are necessary for the efficient operation and good governance of the GPhC.

#### **7. Monitoring and review**

7.1 Committee memberships are reviewed every 12 months.

#### **8. Recommendations**

The Council is asked to approve the membership and chairs of the non-statutory committees as set out in section 2, with effect from 1 April 2022 to 31 March 2023.

Janet Collins, Senior Governance Manager  
General Pharmaceutical Council

02/03/2022

# Minutes of the Audit and Risk Committee meeting held on 7 December 2021

## Minutes of the public items

### Present:

Neil Buckley (Chair)  
Yousaf Ahmad  
Helen Dearden  
Ann Jacklin  
Aamer Safdar

### Apologies:

Jayne Salt

### In attendance:

Duncan Rudkin	Chief Executive and Registrar
Jonathan Bennetts	Director of Adjudication and Financial Services
Rob Jones	Head of Risk Management and Audit
Laura McClintock	Chief of Staff and Associate Director of Corporate Affairs
Gary Sharp	Associate Director of HR
Janet Collins	Senior Governance Manager
Ashley Norman	TIAA

## 1. Attendance and introductory remarks

1.1 The Chair welcomed those present to the meeting. Apologies had been received from Jayne Salt.

## 2. Declarations of interest

2.1 The Chair reminded members of the committee to make any appropriate declarations of interest at the start of the relevant item.

### 3. Minutes of previous meetings – 3 August and 21 October 2021

- 3.1 There were some issues with the minutes of the previous meetings which needed to be rectified before they could be approved. The minutes would be divided into public and confidential items as had previously been the practice and sent to the committee for agreement. They would also be formally approved at the next meeting.

**Action: JC to produce new minutes and circulate to committee**

### 4. Actions and matters arising – public items

- 4.1 An action log had been produced and shared with the committee.

### 5. Item 9 – Internal audit

*Risk management policy – advisory audit*

- 5.1 Ashley Norman (AN) introduced 21.12.ARC.03a, an advisory audit on the GPhC's Risk Management Policy. The findings were very positive. The policy would be reviewed by the Senior Leadership Group in January 2022 and the committee in February as part of the usual review cycle. The audit had been useful in providing independent oversight of the synergy between documents and processes.
- 5.2 There was some discussion about the use of terminology, particularly the use of the HM Treasury Orange Book terms versus those used by the ISO. The committee was reminded that the organisation had taken a clear decision to use the Orange Book terminology as it was more relatable for staff. This had been borne out by the improved quality of conversations about risk that were now taking place. This would be discussed again when the SLG reviewed the policy to be sure that it remained the right decision.

**Action: SLG to consider whether the use of Orange Book terminology remains appropriate**

*Summary internal controls assurance (SICA report)*

- 5.3 There was some discussion about post-lockdown working practices in various organisations. With 35% of companies surveyed saying that home working was 'somewhat effective' (and 63% saying it was 'very effective') there was a question as to whether some staff might be more effective working in the office. DR noted that the GPhC's policy was not 'one size fits all' as it included office attendance for a reason and reasons could vary. Staff wellbeing was also a factor. The executive had expected to see some differences in views by different age groups, but this had not been the case.
- 5.4 The new ways of working would be kept under review to ensure that they remained effective for the organisation and for staff. Managers were being supported with managing productivity and performance. However, checks such as the length of time for which staff were logged in were not being carried out and there were no plans to introduce them. Sickness absence was at a lower level than before the pandemic.

- 5.5 The committee was reassured that the organisations was taking steps to ensure effectiveness in the new ways of working while supporting staff.
- 5.6 **The committee noted the progress against the annual internal audit plan and on the recommendations tracker.**

## 6. Item 10 - Internal Audit plan 2022/23

- 6.1 The committee discussed the internal audit plan for 2022/23. Members welcomed the paper which set out clear options for them to consider. Both the risk registers and the PSA standards had been considered in the planning.
- 6.2 There were three areas which it was suggested should not be audited in 2022/23 as had originally been planned. Budgetary control did not appear to pose significant risk as there was an annual core finance audit and a recent audit of treasury management had shown no issues.
- 6.3 While an audit of performance reporting was in the current plan, it would likely come too early as the work to introduce the balanced scorecard was not due to be completed until 2022/23. It was therefore recommended that this audit was postponed for one year.
- 6.4 The education standards were in the process of being updated, with an advisory group working alongside the Council. Assurance was being gained by other means, although this area would benefit from an audit once the new standards had been implemented.

*Neil Buckley left the meeting and Yousaf Ahmad took the Chair*

- 6.5 There was a discussion as to whether Fitness to Practise should be included in the plan. However, it was agreed that an assessment of the quality of FtP decision making was not really within the auditor's expertise. The committee was content that this was being reviewed by an external legal firm as this was an alternative way to provide assurance.
- 6.6 In response to a question, Gary Sharp (GS) confirmed that the implementation of a new HR system was delayed and that the reference to training and development referred to that provided to the staff. There had been increased expenditure in this area and it would be helpful to ensure that the resources were being well deployed.
- 6.7 It was agreed that a governance audit could be removed for the time being – there had recently been a thorough review and advisory audit of all the major governance documents and the PSA standards in this area were being met. While an audit might provide insight, this was not an area of risk.
- 6.8 A revised plan, taking account of the discussions, would be brought back to the next meeting.

**Action: RJ**



## **7. Any other business**

7.1 There was no other business.

**Date of next meeting: 17 February 2022**