

# Consultation on religion, personal values and beliefs

## First report of the consultation

1. This is the first of two reports analysing responses to our consultation on religion, personal values and beliefs. It focuses primarily on issues related to standard 1 of the new standards for pharmacy professionals, in relation to person-centred care, and the anticipated impact of that change on pharmacy professionals, employers, and users of pharmacy services. A second report will follow, which will include a more detailed analysis of comments received in relation to the guidance on religion, personal values and beliefs in pharmacy practice.

## Policy background

2. Between April and June 2016, we consulted on proposed new standards for pharmacy professionals, which are due to come into force later this year. These nine standards, for which every pharmacy professional is accountable, describe how safe and effective care is delivered through person-centred professionalism.
3. Standard 1 states that pharmacy professionals must provide person-centred care. In the context of religion, personal values and beliefs, the examples of how to apply this standard in practice included the requirement for pharmacy professionals to tell employers or others if their values or beliefs prevent them from providing care, and that they should refer people to other providers of pharmacy services. Many respondents who commented on this standard told us that pharmacy professionals should not be able to refuse to provide services based on their personal beliefs, arguing that this contradicts the principle of person centred care.
4. The new standards for pharmacy professionals were approved in October 2016, subject to further consultation on changes to the examples under the standard 1 which relate to religion, personal values and beliefs. These changes would mean that pharmacy professionals will be required to take responsibility for ensuring that person-centred care is not compromised by their religion, personal values or beliefs. We believe this is compatible with our policy of person-centred care, and better reflects equalities and human rights legislation.
5. If approved, the proposals will change the expectations placed on pharmacy professionals when their religion, personal values and beliefs might impact on their ability to provide certain services, and shift the balance in favour of the needs and rights of the person in their care. While a referral to another service provider may still be appropriate, this will depend on how the referral is carried out, and the pharmacy professional must take responsibility for the continuity and/or outcome of the person's care.
6. Alongside this change in the standards, we also consulted on new supporting guidance. This is intended to help pharmacy professionals apply the standard in practice and reflect the broad range of situations when a pharmacy professional's religion, personal values or beliefs might impact on their ability to provide services.

## About the consultation

7. The consultation was open for twelve weeks, beginning on 13 December 2016 and ending on 7 March 2017. To ensure we heard from as many individuals and organisations as possible:
  - An online survey was available for individuals and organisations to complete during the consultation period, and we also received a small number of postal and email responses
  - We organised a series of stakeholder events aimed at pharmacy professionals, pharmacy service users and other interested parties
  - We also offered one to one meetings with a wide range of organisations that might have a potential interest in the subject matter of the consultation, the majority of whom agreed to meeting with us, and then subsequently submitted responses to the consultation.
  - We also created a toolkit of materials for these organisations to disseminate information about the consultation to their members, including a press release and a presentation.
  - We promoted the consultation with registrants through our online publication Regulate and also promoted it with national and trade media.

## Online survey

8. The online survey asked questions about:
  - the proposed change to the standard
  - revised guidance on religion, personal values and beliefs in practice
  - the impact of these changes on pharmacy professionals, employers and pharmacy services users.
9. We also collected information about respondents' interest in the consultation, and their protected characteristics.
10. 3,450 online responses were received from individuals and members of the public at the point the consultation closed. Alongside these, we also received 151 postal and email responses from individuals and organisations, some using the consultation document, and others writing more generally about their views.

## Stakeholder events

11. The questions in the online survey were also used as a structure for discussion in our stakeholder events:
  - We held pharmacy sector focus groups in England, Scotland and Wales, and a roundtable meeting in London, attracting a mix of pharmacists, pharmacy technicians, people working in education and training, employers, pre-registration pharmacists, and representatives from professional bodies and trade bodies
  - We organised three patient focus groups, in England, Scotland and Wales
  - We also held a discussion with an older people's group, and met with trainees and assessors at Preston College.

12. The questions in the online survey were also used to structure discussions in our stakeholder events, allowing us to capture people's views, and include them in our consultation analysis. These events also used case studies to stimulate discussion on different applications for the standards and guidance in practice.
13. Around 200 individuals and representatives of organisations attended these events.

### One to one meetings

14. We invited a wide range of organisations that might have an interest in the consultation to engage with us directly, so that we could hear their views on the proposals, and discuss in detail the impact on pharmacy professionals, employers and members of the public.
15. As with the stakeholder events, notes from these meetings were captured in a way that allowed them to be included in our analysis of consultation responses. A number of these organisations also submitted postal responses to the consultation, or completed the online survey.
16. We held one to one meetings with 29 organisations during the consultation period.

### Media coverage

17. We promoted the consultation through press releases and social media activity, resulting in considerable media coverage during the period of the consultation.
18. December saw limited media cover, with the pharmacy publications P3 and the Pharmaceutical Journal covering the launch, including comment from the groups Christians in Pharmacy and the Muslim Doctors Association.
19. In January there was further coverage in the Pharmaceutical Journal and C+D during this month and into early February in response to initiatives from the National Secular Society and the Christian Institute amongst others.
20. Around mid-February, the consultation began to receive attention outside the pharmacy press, with blog posts on Conservative Home, Anglican Mainstream and Christian Medical Fellowship websites, the publication of an article and video by the Christian Institute, and a further press release from the National Secular Society. An article was published in The Tablet, one of the UK's most prominent Catholic newspapers, and there was also coverage on two American websites, Life News and National Right to Life News Today. Finally, as the consultation was drawing to a close in March, an article was published in the Catholic Herald.

### Petition

21. On 1 March, a petition against the proposed changes was launched on the website CitizenGO, a campaigning website focusing action on issues related to right to life and religious liberty. 7,782 individuals signed the petition.

## Our overall approach to analysis and reporting

22. We have considered every response received, as well as notes from stakeholder events and one to one meetings. Every response received during the period of the consultation has been considered in the development of our qualitative analysis of themes and issues raised in the consultation. Our thematic approach allows us to represent fairly the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events. We have treated the CitizenGO petition as an organisational response.
23. The variety of routes for individuals and organisations to respond to the consultation means that some duplication is inevitable. For example, some organisations have met with us in one to one meetings, and have also submitted online and postal responses, as well as mobilising individual members to respond to us directly. Again, to ensure we deal with this fairly, we have treated each kind of response in the same way, and focused on the issues that have been raised.
24. Our qualitative analysis can be found in section A of this report, beginning on page 5.
25. Our quantitative analysis of online survey responses from individuals can be found in section B, beginning on page 11.
26. For transparency, we have provided a full list of the organisations that have engaged in the consultation at the end of this report, in section C, on page 21.

# A: Qualitative analysis of consultation responses

27. This section presents a qualitative analysis of responses from individuals and organisations, including online responses from individuals and organisations, as well as postal responses from these groups, notes of engagement events, and notes of meetings with organisations. It should be read in conjunction with the quantitative analysis of the consultation.
28. The report provides summaries of the issues we heard about during the consultation. The focus of this report is particularly on the questions about the proposed changes to the standards and impact on different groups. A second report will focus on the questions around guidance to support registrants in how to meet the standard.
29. An important part of this consultation was a 'self-selection' survey; anyone with an interest in the consultation could respond. 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. Responses cannot therefore be viewed as representative of a larger population, in the way that a probability sample could be. Even where our analysis is broken down into subsets, views are not necessarily representative of wider groups, such as members of the public or pharmacy professionals. To help us understand the nature of the individuals who have responded to this consultation, we have also therefore analysed some of the data on protected characteristics that was collected as part of the consultation. This can be found in section B, and helps to illuminate our qualitative findings.

## Our approach to qualitative analysis

30. A coding framework was developed to identify different issues and topics coming up 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.
31. Open questions were analysed using this coding framework. 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 and coded through the iterative analysis process. The coding frame was used to analyse both responses to the formal consultation survey, as well as notes from meetings and events, and other responses that we received.
32. Our quantitative analysis in section B focuses only on responses from individuals; combining responses from individuals and from organisations (that may represent large numbers of individuals) would create an inaccurate weighting. In this section of the report however, where our focus is on the themes and issues arising from consultation responses, we have considered views from individuals and organisations alongside each other. In our reporting, we distinguished between individual and organisational responses, where it is meaningful to do so.

33. While the quantitative analysis in section B provides a steer to the overall understanding of individual responses, it needs to be read together with this analysis to yield more nuanced, richer views. The combination of both qualitative and quantitative responses allows for a holistic understanding of the issues around and the impact of the proposals.

## What we heard: views on the overall proposal

34. This consultation attracted more responses from members of the public than GPhC consultations typically have. Whereas by far the largest number of individual responses usually come from pharmacy professionals, in this consultation there were more responses from members of the public.
35. The mix of organisations engaging with this consultation was also more varied than typical: we heard from a number of organisations representing different faith groups, or those with secular views, as well as from organisations representing patients and service users in general as well as those with specific protected characteristics. In addition we heard from a number of organisations representing all parts of the pharmacy sector. A list of organisations that engaged in the consultation can be found in section C.
36. The first part of the consultation gauged the extent to which the GPhC's new approach was supported by respondents, and elicited their views on the proposals. Broadly speaking, pharmacy professionals were more likely to agree with the proposals than members of the public. There was a noticeable difference in the overall stance taken by these different groups of respondents to this consultation: the proposed approach was supported by the majority of the pharmacy professionals taking part in the consultation, but objected to by the majority of respondents who identified as members of the public.
37. Analysis of the open questions provides an opportunity to explain and explore these views in more detail. Although there were strong patterns in the responses, it also needs to be recognised that a variety of reasons were given for either agreeing and or not agreeing with the proposed approach. This section seeks to give a summary of the different views heard.
38. Many respondents, both individuals and organisations, saw the proposal as a positive step in further strengthening person-centred care in pharmacy, recognising the positive impact this would have on different groups of service users, by giving them more consistent access to services. In their examples, they referred to a wide range of services, including emergency hormonal contraception. In contrast, a large proportion of the members of the public focused solely on emergency hormonal contraception, overwhelmingly raising this as problematic in the context of the proposed change.
39. On the other hand, in our focus groups with members of the public, overwhelmingly the majority agreed with the proposed approach. Many participants thought the revised example under standard 1 was clear and reflected what was expected of pharmacy professionals by the public. Many also felt that the approach better reflected person-centred care, and that it would help to promote consistent and non-judgmental services for the public. Others commented that the revised approach reflects what they would currently expect from their pharmacy professionals.
40. A similarly complex picture emerged in organisational responses, mirroring responses from individuals. Organisations representing the pharmacy sector tended to be in agreement with the proposals, which those whose work is focused on the interests of particular groups presented a more polarised view.
41. There were some mixed views from participants in our events about how they interpreted the revised example, specifically about whether referral to another pharmacy service provider was still an option, as this word had been removed from the example set out under the standards. While many survey respondents felt the standard and guidance were clear, similarly there were those who were concerned that the wording was ambiguous and too much was left open for interpretation. Indeed there were those, both in support as well as opposition of the overall proposal, who thought the new approach would not

allow for referral and would force professionals to provide any services, even those that would go against their conscience.

42. Some participants in our events felt it was clear that there are many ways for pharmacy professionals to demonstrate that they are taking responsibility to ensure care is not compromised, including making referrals to other providers in appropriate cases. However, other participants interpreted the example to mean that pharmacy professionals would always be required to provide services which they may object to because of their religion, personal values or belief, if the services are legal and safe for the person.

### Rationales for supporting the proposals

43. Of the individual respondents who broadly supported the proposal, many simply expressed that the needs of pharmacy service users should always come first and that pharmacy professionals should not impose their personal values or beliefs on those using services. Some respondents commended the proposals for the emphasising the active role a professional should take in ensuring the continuity of care, many mentioning that it was “about time” this change was happening.
44. There were also those who felt the proposal didn’t go far enough and that professionals should never refuse service because of personal and religious beliefs, particularly where such services were part of NHS provision. It was emphasised that patients should have a right to any legal, clinically appropriate service.
45. Overall, many of those supporting saw the approach as strengthening current practice and giving further clarification on the responsibilities of professionals. They also saw this as a positive step for service users who would benefit from improved, more consistent access to services and better quality, non-judgmental care.
46. There were also respondents who supported the proposal and who in their open response identified as having religious beliefs, yet emphasised that as health professionals the needs of the person seeking care would always be their primary focus. Others noted that religious beliefs are often important in positively informing a practitioner’s professional ethics, and it is not desirable to separate these two as long as the outward manifestations of personal values and beliefs are not imposed on those receiving care.
47. Some professionals noted that personal values and beliefs can have a positive impact on practice and care, however they felt the tone of the consultation document and the draft guidance unnecessarily problematized religion. It was said the tone could be more balanced recognising the positive impact of strong personal values and beliefs can have on healthcare practice.
48. Broadly, the organisations that supported the proposals were pharmacy organisations, explicitly secular organisations, and organisations representing different groups of health service users, as well as some faith based organisations. In their responses, many recognised the difficulties in this area and raised important points for further consideration, which will be more fully addressed in the context of producing guidance to support the implementation of the standard. On the whole, these organisations welcomed the strengthened focus on person-centred care and the active role professionals would play in ensuring care is not compromised. At the same time there was recognition that balancing the rights of both service users and professionals is not easy. Many respondents also asked further clarification on the implementation of the new standards, for example in the context of existing employment or possible fitness to practise implications.

49. Both individuals and organisations made references to the employment law and how the proposed approach would align with this. There were also those who commended the approach proposed for restating equality, non-discrimination and human rights principles as key to effective person-centred care.

### Rationales for opposing the proposals

50. It is important to note that opposition or support was not always related to whether or not respondents identified themselves as having religious beliefs. Some saw the proposal simply as a further erosion of professional autonomy and decision-making, without necessarily making reference to religious beliefs, and objected to proposal on this basis.
51. Those who opposed the proposals stated that pharmacy professionals should not be put in a position where their values and personal beliefs are compromised. There were many in this group of respondents who took the proposal as saying that a pharmacy professional would have to personally provide all services and that referral was never an option. Many of these answers raised concerns, explicitly or implicitly, that the regulator is effectively forcing pharmacy professionals to provide services that go against their personal values and beliefs. Many respondents also said that neither the regulator nor patients should impose their values on professionals. Some respondents wanted the values and beliefs of both pharmacy service users and pharmacy professionals to be balanced, so that neither group would be disadvantaged.
52. There were also some who felt that taking part in any way in provision of services that went against a professional's personal beliefs, whether this was by referring or in any other way, would not be right. Concerns were raised that the new approach would infringe on professionals' rights, causing some to leave the profession and increasing the likelihood of pharmacy professionals, particularly those with religious beliefs, being discriminated against by employers.
53. There were also some, who were concerned that the approach would enable pharmacy service users to demand any services they want, rather than services being provided based on clinical need.
54. Finally, there were many who considered emergency hormonal contraception as being an abortifacient, and who consequently thought that supplying it, or even making a referral to another pharmacy professional, would constitute taking part in an abortion; they objected to the proposed approach on this basis.
55. Organisations opposed to the new approach based their stance on the interpretation that the new proposal would require pharmacy professionals to supply medicines or services even when this was against their conscience. Many of these responses challenged whether the approach would be in line with equalities legislation, or in breach of article 9 of the European Convention of Human Rights. Some respondents felt the new approach could benefit employers and could open the door for discrimination against employees.
56. Some organisations who did not agree with the new approach said they were however in support of person-centred care. They raised concerns that pharmacy services users would be enabled to choose any medication that they felt fit, rather than this being a decision by the professional.

57. A further problematic area that was particularly of concern to those who were opposed to the proposed approach was the role of pharmacy professionals in assisted dying should the law in this area change in future.
58. Finally, it was commented that the overall tone of the document seemed to problematize the public practice of religion, personal values and beliefs, almost as if to say these do not have a place in healthcare. Furthermore, some respondents noted the lack of reference to 'conscience' and 'conscientious objection' in the standards and guidance. Several comments were made in reference to the approach by the General Medical Council which they perceived as better.

## **What we heard: impact of the new approach on pharmacy professionals, employers and pharmacy service users**

59. The second part of the consultation survey focused on the possible impact of the new approach on three groups: pharmacy professionals, employers and people using pharmacy services.
60. Again there was a notable difference between how the different groups responded to the online survey, with pharmacy professionals typically viewing the likely impact on different groups as being both negative and positive, and a majority of members of the public viewing the likely impact as a negative.

### **Impact on pharmacy professionals**

61. In the comments on the impact on professionals, it was frequently mentioned that some pharmacy professionals might leave the profession as a result of the proposed changes. This was raised by both those who supported the proposal and those who did not, and seen as both a positive and a negative outcome. Some concerns were raised about the diversity of the workforce and how this could decrease as a result.
62. And yet, some professionals also felt the proposed approach would bring much needed clarity: professionals would know where they stand, and prospective students would know what is expected of them on entering the pharmacy workforce.
63. On the other hand, some respondents, whether they supported or opposed the approach, thought the new approach could also have negative impact on professionals navigating a new situation. Those opposed to the plans felt this would infringe on the rights of those who feel unable to provide certain services because of religious beliefs, indeed this was at times seen as infringing on those individuals' rights. It was feared that this could have an impact on employment opportunities. Furthermore some felt that the pressure to act against own values and beliefs was likely to give rise to stress, anxiety and overall have mental health implications on some professionals.
64. There were many who felt the changes would merely reinforce current practice, and those who felt there will be no impact on practice at all, suggesting that pharmacy professionals would simply carry on as they have done to date.
65. A small group opposed to the proposals not on religious grounds but because they felt the new approach would erode professional autonomy and professionals' ability to exercise their own professional judgment.

66. While some respondents recognised this could be a problematic change for some professionals, it was felt that on the whole the change would be beneficial to pharmacy service users, whose care should be the first priority and this approach would further strengthen this.

### Impact on employers

67. On the positive side, it was felt the proposal would bring clarity and there would be an improvement to both quality of care and services. Continuity of service provision would be improved and there would be less of a risk for services not being available.
68. The implementation of the proposed approach raised questions, and this was an area where many respondents wanted further clarity: how would the proposals be implemented in practice, how would employers balance the new requirements with employment law, how would they manage any situation with current employees, and would there be fitness to practice implications. Implementation was an area where further guidance would be needed.
69. Those who strongly opposed to the proposals on religious grounds pointed out that there were likely to be employers who would feel they had to go against their personal values and beliefs.

### Impact on pharmacy service users

70. Overwhelmingly those who supported the GPhC's proposal felt that it would benefit people using pharmacy services by enshrining their needs as a priority, ensuring that access to care would not be compromised, and that the availability of services would be more consistent. Several respondents mentioned that service users would be able to seek services without being made to feel they were judged, and that they would also be able to access services in a timely manner, which can be critical for the efficacy of certain medicines.
71. However a very different picture emerged in the responses of those who opposed to the proposals. It was felt that the quality of services and care would deteriorate as professionals would have to act against their beliefs or leave the profession altogether. Further, many commented that service users with religious beliefs would not be able to seek advice from a professional with similar beliefs.
72. In our patient focus groups, many participants talked about examples of the types of barriers that a person might face when trying to access services and some people gave personal examples. Most participants agreed that it would be important for pharmacy professionals to consider these types of issues or barriers when providing person-centred care. The majority of participants raised privacy and confidentiality as important issues, feeling that the new approach would give assurance to pharmacy services users that they would be treated with dignity and respect.
73. Participants across the different groups also recognised that this is a difficult and complex area for pharmacy professionals. However, many felt that potential difficulties could be managed by pharmacy professionals having open and honest conversations with their employers and making advance arrangements for service provision.
74. Across all groups, participants felt it was important that students, or people considering a career in pharmacy, are informed about the standards expected of pharmacy professionals at an early stage.

## B: Analysis of individual online survey responses

75. This section presents a quantitative analysis of online survey responses from individuals. 3,450 online responses were received at the point the consultation closed on 7 March 2017. In preparing this analysis, decisions to include and exclude a small number of responses were made for reasons set out below:

- Organisational responses are treated separately in the qualitative analysis. This is to take account of those organisations that are representative bodies, to ensure that their views are given appropriate weight, compared to those of an individual respondent.
- A small number of respondents (less than 10) who had indicated they were responding on behalf of an organisation were reclassified as individual respondents, and are included in this analysis. Half of these had chosen to respond anonymously, while other respondents identified themselves as members of organisations that had sent an official postal response to the consultation.
- A slightly larger number (less than 40) 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 analysis.

76. In total, 3,361 individual online responses are included in this analysis.

### Survey structure

77. The survey contained a mixture of quantitative questions: binary questions, for example, "do you agree with these changes?"; questions with scales, for example, "will the impact be..."; and multiple choice questions, for example, "where do you live?". There were also a number of open ended questions.

78. Every response to an open ended question (including those included and excluded as above) has been read, analysed, considered and coded in the preparation of the qualitative analysis, in section A.

79. This report sets out a summary of individual online responses to the quantitative questions only.

## Exploring differences between groups

80. This analysis highlights differences between two pairs of subsets of respondents: members of the public and pharmacy professionals; and respondents with religious beliefs and with no religious beliefs. The rationale for presenting results for these subsets, and the methodology for creating these groups, is set out below.
81. Although these subsets are included in the report, it is important to underline that these results cannot be taken as representative of others who share the same characteristics. Respondents to the consultation are particularly motivated to respond, and overall the results are subject to self-selection bias. The subsets do however illustrate the variety of views between and within each of these groups, and underline that those who share characteristics, for example having a religious belief, will not necessarily share the same opinions.

### Members of the public and pharmacy professionals

82. Unusually for a GPhC consultation, a very large number of responses were received from members of the public (n=1,780), with more responses from these individuals than from pharmacy professionals (n=1,372). Given that the proposals on religion, personal values and beliefs would affect pharmacy professionals and members of the public differently, the responses of these groups are set out as subsets of the whole. Other groups, such as pre-registration trainees, had small numbers of respondents overall and are not presented separately.

### Respondents with religious beliefs and no religious beliefs

83. The survey also asked respondents a series of questions about their protected characteristics, as defined in the Equality Act 2010. Given the relevance of the proposals to religion, two further subsets of respondents have been identified: those who indicated that they have religious beliefs (n=2,049) and those who do not (n=772).
84. The subset of respondents with religious beliefs includes all those individuals who selected one of the six religious groups identified in the survey: Buddhist, Christian, Jewish, Hindu, Muslim or Sikh.
85. The subset of respondents with no religious beliefs includes all those individuals who selected None.
86. Those who selected Other, and who completed a free text responses, fall into three groups:
  - Individuals whose responses could be allocated to an existing category, for example Church of England, Roman Catholic, or Pentecostal, have been included for analytical purposes as part of a larger group, for example Christian, and have been included in the subset of respondents with religious beliefs.
  - Individuals who identified themselves as members of religious groups not identified in the survey, for example Jain or Pagan, and have been included in the subset of respondents with religious beliefs.
  - Individuals who identified themselves as affiliated with non-religious belief systems, such as Atheist and Humanist, have been included in the category None, and the subset of respondents with no religious beliefs.
87. Respondents who selected Prefer not to say, or who skipped the question, have not been presented separately.

### How the pairs of subsets relate to each other

88. Among members of the public, 1,006 (56.5%) are included in the subset of those with religious beliefs, and 451 (25.3%) in the subset of those with no religious beliefs. Among pharmacy professionals, 923 (67.3%) have religious beliefs, and 292 (21.3%) have no religious beliefs.

### Detailed analysis

89. The tables below present the number of respondents selecting different answers in response to questions in the online survey. The ordering of relevant questions in the survey has been followed in the analysis.
90. Because of the sensitive nature of some of these questions, cells with fewer than 10 respondents have been expressed as <10. Consequently, the tables are presented without totals or percentages, so that small numbers cannot be identified by calculation. Skipped answers have not been included. Cells with no data are marked with a dash.
91. Where there are notable differences in responses between subsets, these have been described in the supporting narrative.

### About respondents

92. A series of introductory questions sought information on individuals' general location, and in what capacity they were responding to the survey.
93. For pharmacy professionals, further questions were asked to identify whether they are pharmacists, pharmacy technicians or pharmacy owners, and where they usually work.

#### Where do you live?

	All	Public	Pharmacy	Religion	None
England	2705	1454	1130	1649	630
Scotland	321	161	136	209	66
Wales	163	94	62	99	45
Northern Ireland	40	19	<10	28	<10
Other	80	39	30	48	19

#### Are you responding as

	All	Public	Pharmacy	Religion	None
A member of the public	1780	1780	-	1006	451
A pharmacy professional	1372	-	1372	923	292

A pre-registration trainee	32	-	-	21	<10
A student	67	-	-	45	<10
Other	49	-	-	20	<10
Other healthcare professional	55	-	-	31	11
Other student	<10	-	-	<10	<10

#### Pharmacy professionals: part of the register

	All	Public	Pharmacy	Religion	None
Pharmacist	1127	-	1127	761	226
Pharmacy technician	195	-	195	126	58
Pharmacy owner	30	-	30	20	<10

#### Pharmacy professionals: usual workplace

	All	Public	Pharmacy	Religion	None
Community pharmacy	780	-	780	544	147
Hospital pharmacy	307	-	307	194	81
Pharmaceutical industry	37	-	37	27	<10
Pharmacy education and training	55	-	55	35	12
Primary care organisation	98	-	98	69	22
Other	77	-	77	39	23

94. The distribution of individual respondents across England, Scotland and Wales is broadly similar to the distribution of the UK population, and there are no notable differences between the subsets of members of the public, pharmacy professionals, those with religious beliefs and those with no religious beliefs.
95. In terms of types of respondents, the largest group identified themselves as members of the public (53%) followed by pharmacy professionals (40.8%). Further characteristics and differences between these groups can be found in the final section of this analysis.
96. Among pharmacy professionals, the number identifying themselves as pharmacy owners is notably small (2.2%). However, this group had two potential routes to respond to this consultation: as individuals, and on behalf of organisations. Responses from organisations have been dealt with separately.
97. Just over half of pharmacy professionals responding to the survey (57.6%) identified community pharmacy as their usual workplace. 22.7% of respondents work in hospital pharmacy, with the remainder in other locations.

## Consultation questions

98. The core questions in the survey focused on respondents' views of the proposals in the consultation. Responses were sought on questions relating to agreement with the standards, and the adequacy of the proposed guidance.
99. Questions were also asked about the expected impact of the proposed changes, and what the nature of that impact would be, on a five-point Likert scale from mostly positive to mostly negative. These questions focused on impact on three different groups: pharmacy professionals, employers and users of pharmacy services.

### Q1: Do you agree with the proposed changes?

	All	Public	Pharmacy	Religion	None
Yes	1520	505	952	691	733
No	1811	1269	414	1352	38

100. Overall, 45.6% of respondents agreed with the proposed changes.
101. There are notable differences between subsets. Among the public, 28.5% agreed with the proposed changes, compared to 69.7% of pharmacy professionals. 33.8% of respondents with religious beliefs agreed, compared to 95.1% of respondents with no religious beliefs.

### Q2: Does the revised guidance adequately reflect the broad range of situations that pharmacy professionals may find themselves in?

	All	Public	Pharmacy	Religion	None
Yes	1716	653	987	897	680
No	1335	871	357	959	77

102. 56.2% of respondents agreed that the revised guidance adequately reflected the broad range of situations that pharmacy professionals might find themselves in. Among members of the public, the level of agreement decreases to 42.8%, whereas it rises to 73.4% among pharmacy professionals. Between those with religious beliefs and those with no religious beliefs, this difference is more marked, with 48.3% of those with religious beliefs agreeing, compared to 89.8% of those with no religious beliefs.

### Q4: Will our proposed approach to the standards and guidance have an impact on pharmacy professionals?

	All	Public	Pharmacy	Religion	None
Yes	3025	1653	1201	1885	676

No	220	44	163	129	69
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**Q5: Will the impact [on pharmacy professionals] be**

	All	Public	Pharmacy	Religion	None
Mostly positive	906	374	501	359	501
Partly positive	131	32	92	73	52
Positive and negative	492	121	347	307	137
Partly negative	366	214	129	278	24
Mostly negative	1321	955	268	986	20

103. Overall, 93.2% of respondents noted that the proposals would have an impact of pharmacy professionals, with little notable variation between the subsets. There were however marked differences in how different groups assessed the nature of that impact. Among pharmacy professionals themselves, 44.4% thought the impact would be mostly or partly positive, with 29.6% assessing the impact as mostly or partly negative; members of the public believed the impact on pharmacy professionals would be substantially more negative, with 68.9% assessing the impact as mostly or partly negative. Comparing respondents based on religion reveals 63.1% with religious beliefs believe the impact on pharmacy professionals would be mostly or partly negative, compared to 75.3% of those with no religious beliefs considering the impact to be mostly or partly positive.

**Q6: Will our proposed approach to the standards and guidance have an impact on employers?**

	All	Public	Pharmacy	Religion	None
Yes	2685	1470	1059	1673	607
No	418	108	287	235	132

**Q7: Will the impact [on employers] be**

	All	Public	Pharmacy	Religion	None
Mostly positive	813	336	450	322	447
Partly positive	180	35	139	108	53
Positive and negative	590	171	383	372	156
Partly negative	346	219	104	266	18
Mostly negative	1029	770	184	764	14

104. In considering impact on employers, the most marked differences are between the views of the public and pharmacy professionals. 78.8% of pharmacy professionals believed there would be an impact on employers, compared to 93.2% of the public. The nature of this impact was also assessed differently: members of the public and those with religious beliefs largely believed the impacts to be mostly or partly negative (64.6% and 56.2% respectively) while those with no religious beliefs believed the impacts would be mostly or partly positive (72.7%). Views among pharmacy professionals were more mixed. 46.7% believed the impact would be mostly or partly positive, with a substantial proportion (30.4%) rating the impact as positive and negative.

**Q8: Will our proposed approach to the standards and guidance have an impact on people using pharmacy services?**

	All	Public	Pharmacy	Religion	None
Yes	2698	1435	1115	1608	707
No	476	211	232	342	46

**Q9: Will the impact [on people using pharmacy services] be**

	All	Public	Pharmacy	Religion	None
Mostly positive	1259	477	742	530	659
Partly positive	146	37	102	103	30
Positive and negative	528	219	262	402	35
Partly negative	260	178	61	200	<10
Mostly negative	797	633	109	586	11

105. Overall, 85.0% of respondents thought the proposals would have an impact on people using pharmacy services, with little variation between the four subsets.
106. Among members of the public themselves views of the nature of the impact were particularly polarised, with 33.3% respectively assessing the impact as mostly or partly positive, and 52.5% viewing it as mostly or partly negative.
107. Further analysis of public responses was undertaken to explore the views of those groups that might positively benefit from the proposals, as identified in the equality impact analysis. Although the number of respondents is small, it is notable that 39.6% of women aged 20-39, 44.1% of those with a disability, and 66.7% of LGBT respondents considered the impact of the changes would be mostly or partly positive, compared to 33.3% of members of the public as a whole.
108. Among pharmacy professionals, 66.1% assessed the impact on people using pharmacy services as being mostly or partly positive. Among those with religious beliefs, 34.8% viewed the impact as mostly or partly

positive, and 43.2% as mostly or partly negative. Among those with no religious beliefs, the proportion assessing the impact as mostly or partly positive rose to 93.2%.

## Monitoring questions

109. In the final section of the survey, data was collected on respondents' protected characteristics, as defined within the Equality Act 2010. The GPhC's equalities monitoring form was used to collect this information, using categories that are aligned with the census, or other good practice (for example on the monitoring of sexual orientation). These questions were asked to help understand the profile of respondents to the consultation, to provide assurance that a broad cross section of the population had been included in the consultation exercise. The responses on religion have also been used to help illuminate differences in responses between with religious beliefs and those with no religious beliefs.

### What is your sex?

	All	Public	Pharmacy	Religion	None
Female	1484	634	762	1013	329
Male	1625	981	560	999	429
Other	30	17	10	11	<10

### What is your sexual orientation?

	All	Public	Pharmacy	Religion	None
Bisexual	34	18	<10	11	23
Gay man	55	22	28	22	30
Gay woman/ lesbian	16	<10	<10	<10	10
Heterosexual/straight	2532	1247	1153	1756	643
Other	26	20	<10	16	<10
Prefer not to say	425	277	120	184	45

### What is your age?

	All	Public	Pharmacy	Religion	None
Under 20	33	11	<10	25	<10
20 – 29 years	382	99	211	249	86
30 – 39 years	575	186	365	360	148
40 – 49 years	604	249	341	363	180
50 – 59 years	654	348	281	430	151
60 + years	845	700	126	586	192

### Do you consider yourself disabled?

	All	Public	Pharmacy	Religion	None
Yes	162	124	29	92	54
No	2751	1353	1244	1841	688
Prefer not to say	198	132	52	79	20

### What is your ethnic group?

	All	Public	Pharmacy	Religion	None
White	2382	1390	892	1518	700
Black or Black British	103	15	74	101	<10
Mixed	68	24	35	54	10
Asian or Asian British	254	19	203	223	17
Chinese or Chinese British	17	<10	11	12	<10
Arab	18	<10	15	16	<10
Other	16	<10	<10	14	<10
Prefer not to say	246	145	83	77	28

### What is your religion?

	All	Public	Pharmacy	Religion	None
Buddhist	19	<10	10	19	-
Christian	1737	980	664	1737	-
Hindu	70	<10	67	70	-
Jewish	18	<10	15	18	-
Muslim	151	<10	128	151	-
Sikh	22	<10	20	22	-
Other	32	<10	19	32	-
None	772	451	292	-	772
Prefer not to say	318	178	109	-	-

110. In terms of their protected characteristics, there are few differences in the profiles of those with religious beliefs and those with no religious beliefs, with the obvious exception of religious beliefs themselves.
111. The profile of members of the public and pharmacy professionals who answered these questions was also broadly similar, with a few notable exceptions. Members of the public were more likely to be male (60.1% against 42.0%), more likely to be white (86.6% against 67.5%) and more likely to be Christian (59.9% against 50.2%).
112. However, the most notable difference between these two subsets relates to the age profile of respondents. As with other characteristics, the age profile of pharmacy professionals responding to the survey is broadly similar to the GPhC's register. The age profile of members of the public strongly tends towards older age groups, with 21.8% of respondents aged 50-59, and 43.9% aged 60 years or older.

## C: Organisations

The following organisations engaged in the consultation through one to one meetings, attendance at events, providing evidence for our equality impact assessment, and submitting responses to the consultation.

- Acheason Chemist
- Acorn Chemist
- Affinity - Gospel Churches in Partnership
- Anscombe Bioethics Centre
- Association of Pharmacy Technicians United Kingdom
- Association of Independent Multiples Pharmacies Committee
- Badham Pharmacy Ltd
- Bairds Pharmacy
- Bedfordshire Humanists
- BLM
- Board of Deputies of British Jews
- Boots Pharmacists' Association
- Boots Pharmacy
- British Association of Gender Identity Specialists
- British Humanist Association
- British Pharmaceutical Students' Association
- British Pregnancy Advisory Service
- Buddhist Council of Wales
- Buttercups Training Ltd
- Carters Chemist
- Catholic Bishops Conference of England and Wales
- Catholic Medical Association
- Catholic Nurses Association
- Catholic Parliamentary Office
- Catholic Union of Great Britain
- Celesio UK

- Centre for Pharmacy Postgraduate Education, University of Manchester
- Charles Russell LLP
- Chief Pharmaceutical Officer, Scotland
- Christian Action, Research and Education
- Christian Institute
- Christian Legal Centre
- Christian Medical Fellowship
- Christian Voice
- Christians in Pharmacy
- Church of England
- CitizenGO
- Community Pharmacy Scotland
- Community Pharmacy Wales
- Croydon Local Pharmaceutical Committee
- D K Wood Ltd
- Dalton Pharmacy
- Evangelical Alliance
- Faculty of Sexual and Reproductive Health
- Fairmans Pharmacy
- Family Education Trust
- Family Planning Association
- Free Church Council of Wales
- Friends, Families and Travellers
- General Medical Council
- GIRES
- Guild of Healthcare Pharmacists
- Hampshire and Isle of White Local Pharmaceutical Committee
- Healthwatch Islington
- Healthwatch Lewisham
- Healthwatch Salford

- Hindu Council UK
- Housley Pharmacy
- Jewish Medical Association
- Kamsons Pharmacy
- Lawyers Christian Fellowship
- LGBT Foundation
- Life
- Lindsay & Gilmour
- Mencap
- Midcounties Co-operative
- Mind
- Morrison's Pharmacy
- Muslim Council of Britain
- Muslim Pharmacists Association
- National Dignity Council
- National LGB&T Partnership
- National Pharmacy Association
- National Secular Society
- Network for Buddhist Organisations
- NHS Ayrshire and Arran
- NHS Education for Scotland
- NHS England Health and Justice Commissioning
- NHS Lanarkshire
- NHS Wandsworth Clinical Commission Group
- Norchem Healthcare
- PCT Healthcare Ltd
- Peverell Community Church
- Pharmaceutical Services Negotiating Committee
- Pharmacists Defence Association
- Pharmacy Law and Ethics Association

- Pharmacy Schools Council
- Pharmacy Voice
- Preston College
- Professional Standards Authority
- ProPharmace
- Race Equality Foundation
- Redbridge Pensioners Forum
- Right To Life
- Rowlands Pharmacy
- Royal Pharmaceutical Society
- School of Pharmacy, Keele University
- Scottish Catholic Medical Association
- Scottish Council of Human Bioethics
- Scottish Secular Society
- Secular Medical Forum
- Secure Environment Pharmacists Group
- Society for the Protection of Unborn Children
- South Staffordshire Local Pharmaceutical Committee
- Spring Road Evangelical Church
- Sykes Chemists Ltd
- Terrence Higgins Trust
- The Baptist Church, Kilmington
- The Christian Institute
- The International Vegan Rights Alliance
- The National LGB&T Partnership
- The Vegan Society
- Twickenham Christian Concern
- University of Bradford
- Uttoxeter Health Stores Ltd
- Vyas Ltd

- Well