Department of Health
Professional Regulation
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January 2018

Dear Colleague

Consultation on promoting professionalism, reforming regulation

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain. The RPS leads and supports the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

The RPS has answered the questions asked by the Department of Health (DH) in its consultation discussion paper as follows:

Protecting the public

The Health and Care Professions Council (HCPC) is the only regulator that has the legislative power to recommend that a group should be statutorily regulated. As the HCPC has traditionally been the regulatory body to assume regulatory oversight of new groups, it could be seen to have a vested interest in expanding its registrant base. The DH therefore believe that the Professional Standards Authority (PSA), working with relevant stakeholders, would be better placed to provide advice on the regulation of professions.

Q1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

Yes	☒
No	☐

The PSA has set out proposals for assessing whether professional groups should be regulated. It has proposed a two stage assessment. The first stage considers evidence of risk of harm in three key areas. These are:

- the complexity of the activities/intervention undertaken;
- where the intervention occurs (for example in a hospital or someone's home); and
- the vulnerability/autonomy of the patient and their ability to make an informed choice about their care.

The second stage considers wider external policy factors. These could include:

- the scale of the risk - the size of the professional group or number of patients who are treated;
- means of assurance - the range of different ways in which the risk of harm can be reduced;
- sector impact - the impact that regulation (or other means of oversight) would have on cost and supply of the workforce;
- risk perception - the effect that regulation (or other means of oversight) would have on the confidence levels for the relevant profession; and
- unintended consequences of the preferred form of oversight.

Q2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

The RPS requests that a stronger evidence based approach is taken to regulatory oversight with consideration of patient and public safety the key criteria. It is also important to consider the public and patients' perception of the healthcare professional and their expectations about statutory oversight of a professional group. The means of assurance should also take into account transfer between settings e.g. the patient's home and secondary care as there is much evidence that this where there is the greatest risk – particularly with medicines.

The first stage assessments appear appropriate as they consider the vulnerability of patients from the actions of the health care professional (HCP) and the potential opportunity of the HCP to cause harm. However complexity of activity is subjective and levels would need to be clearly defined to ensure consistency. It should also be recognised that more complex interventions take place in the home now, than would have traditionally (e.g. the administration of chemotherapy), so this would need to be considered carefully if used as a key criterion. The second stage criteria appear to be less relevant, as they are focussed on the size of the professional group, cost etc. - It is also unclear how the two parts of the assessment link.

The current system needs to demonstrate greater transparency with the risk management approach e.g. pharmacy technicians are regulated but cardiac physiologists (who support cardiac surgery and catheter laboratories) are not. Duplication of regulation should also be avoided wherever possible.

There is much emphasis on 'employers' although there are many self-employed and agency/ locum staff in healthcare – this needs to be taken into account with system regulation i.e. clarity on various contracted models.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight?

Yes	☒
No	☐

Which groups should be reassessed as a priority? Why?

The RPS believes that a reassessment of the current groups regulated by the General Pharmaceutical Council is unnecessary and unlikely to change the need for pharmacists and pharmacy technicians to be regulated because of the risks associated with medicines. Any future reassessment should fully consider and understand the different and newer roles undertaken by pharmacists and pharmacy

technicians. This includes pharmacists who are becoming independent prescribers in increasing numbers. There should also be an assessment of registration of Pharmacy Technicians in NI to ensure alignment with registration in GB.

In addition, pharmacists and pharmacy technicians will be undertaking revalidation from 2018 (previously they were required to submit nine Continuing Professional Development (CPD) records per annum by the regulator). Revalidation for pharmacy has been a bespoke development and differs from medicine and nursing so any deregulation of groups may risk reducing engagement with professional development and lifelong learning. The impact of revalidation on patient safety needs further research.

Groups who are currently not subject to regulation and are not part of an accredited register should be assessed as a priority since this is potentially a greater risk to public safety at this time. This should be followed by all currently regulated groups.

The Law Commissions recommended that regulatory bodies be given powers to operate a form of negative register through the use of prohibition orders for those groups not subject to statutory regulation. Such a scheme allows individuals to be barred from practising a specified profession or from carrying out specific activities and would set the standards required of a certain occupation.

Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

Prohibition orders may alleviate some of the issues associated with protecting public and patients without resorting to statutory regulation (and the associated costs) but should only be used as a last resort and are likely to have a limited impact as it is not clear how such a process would be implemented and monitored.

Prohibition orders may operate as a negative register but there are potential shortcomings. Firstly there is a great deal of emphasis on the role of the 'employer' in the consultation document and some of those not subject to statutory regulation will not be 'employed' in the traditional manner. The younger workforce work more flexibly than previous generations, including undertaking portfolio roles. These newer models of working need to be considered if a negative register is to be effective. Secondly, those groups who are not currently regulated are also unlikely to be subject to the use of legally protected titles; therefore there is a potential that a 'professional' could be prohibited under one title but set themselves up as a different 'professional' without any form of registration and may appear to the public to be bona fide.

The use of the terms 'regulated professional' and 'professional' would need to be communicated in a manner that the public understand so they can feel assured about the safety of service offerings and make informed decisions.

Another alternative approach would be to expand the current Disclosure & Barring Service (DBS) system to identify individuals who are not fit to practice in a particular role.

There are currently nine regulatory bodies, which range significantly in terms of numbers of individuals regulated and number of professions regulated. Some regulators regulate just a few thousand professionals while others regulate several hundred thousand. The HCPC regulates 16 professions, the Nursing and Midwifery Council regulates two, while others regulate just one profession. As well as regulating professions, the General Pharmaceutical Council (GPhC) and the Pharmaceutical Society of Northern Ireland (PSNI) regulate pharmacy business premises and the General Optical Council (GOC) regulates optical businesses

Q5: Do you agree that there should be fewer regulatory bodies?

Yes	☒
No	☐

Q6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

Any review should put the safety of patients and wider public at the centre and not primarily focus on driving efficiencies. Also the review of professional regulation should be taken along with a review of system regulation (including accredited registers for clinics), given that there is an interdependency for good governance principles between professional and system regulation – pharmacy is such an example but there are others. Furthermore, the role of quality accreditations for services such as pathology should be reviewed against the requirements for system regulation.

The core standards for professionals are broadly similar and could be standardised. However, rationalisation needs to be undertaken with safety of the patient as the focus. Consideration is needed of the maturity of the professional leadership bodies in each case and how they are configured to provide similar levels of support. Professional body membership should be compulsory if there are fewer regulators - specific professional leadership bodies can provide standard setting and support, since e.g. HCPC standards are not as detailed for each professional group.

***Advantages** – economies of scale, possibly reduced registration fees, greater commonality and consistency of shared multi-disciplinary standards and revalidation processes. Reduced duplication and regulatory burden e.g. prescribing courses are currently regulated by a range of different regulators.*
Also greater efficiency - has the potential to improve the quality of outputs of regulators in terms of focusing on quality improvement in the areas of professionalism, particularly behaviours and human factors.
***Disadvantages –** misunderstanding of the diversity of different professions such as pharmacy which may lead to disproportionate regulation and revalidation requirements. Additional complexity for a merged body may actually cause inefficiencies and greater costs. Also: loss of identity of individual professions, risk of inappropriate standardisation where there is warranted variation between professions, risk that smaller professions are overlooked due to their minority in numbers, i.e. seen as less important and requiring less resource.*

Q7: Do you have views on how the regulators could be configured if they are reduced in number?

The complexity and breadth of the roles pharmacists undertake mean that there is significant risks from merging pharmacy regulation with other regulators. The Royal Pharmaceutical Society does not believe there is a case for merging pharmacy regulation with the regulation of others.

The RPS believes that there would be advantages in merging the GPhC and the Pharmaceutical Society of Northern Ireland (PSNI). This should provide greater efficiency and reduced duplication with shared standards achieved across the United Kingdom. The RPS could provide the professional leadership function that is currently delivered by the PSNI.

The evidence for merging regulators needs to be explicit and should primarily focus on patient and public safety rather than cost. Pharmacy is currently the third largest workforce in the healthcare

system, the delivery of pharmacy practice is unique to pharmacists and their teams (and underpinned by the Medicines Act) and the GPHC's register is growing year on year, so it is not clear that merging with another regulator would be of benefit. Consideration could be given to the CQC taking over regulation of pharmacy premises so that consistent standards are applied.

If it was deemed absolutely necessary to merge the GPhC with other regulators outside pharmacy the RPS believes that the least worst option would be merging with regulators of professions with a similar level of education and diversity of workforce such as the General Dental Council and the General Optical Council. However, this creates risks with development of bespoke professional standards for pharmacy and the role of the RPS should be considered here to ensure no gaps in patient and public safety are inadvertently created.

The RPS would not support a merger of the GPhC with any of the other regulators because of differences in education of other professional groups (HCPC, GCC, GOsC) or dilution and loss of specialist regulatory knowledge (GMC, NMC).

There should be a cross cutting review of how the services are delivered by professionals, including in the context of system regulation. For example the GPhC/PSNI, GOC and GDC should operate consistent models of both professional and system regulation since the patient journey is similar and includes self-referral from a 'close to home' setting.

There will be many options but any review will need to consider new and evolving technologies. In addition the breadth of those professionals involved in wellbeing services, who may fall outside current regulation / accredited registers, will need to be considered, particularly in light of the increasing demand with mental health needs.

Responsive regulation

The strong focus on fitness to practise and conducting cases in an adversarial way affects the outlook and culture of the regulatory bodies. The legalistic and defensive nature of the regulators can make them seem unapproachable and bureaucratic to both complainants and registrants. DH believes that this needs to change.

The Law Commission recommended a number of improvements to the current procedures that would give the regulators greater flexibility and discretion over how to process and investigate fitness to practise cases. Other suggestions included making the triage process more robust and increasing the use of dispute resolution and mediation to manage concerns.

When fitness to practise is not impaired, regulators cannot impose a sanction. However, some regulators may issue a warning or impose conditions, if conduct, behaviour or performance has significantly departed from professional standards. This range of powers should mean that regulators are able to take proportionate action in response to the issue that is before them. However, not all of the regulatory bodies have the full range of powers at their disposal.

Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

Yes	☒
No	☐

For patient confidence in and understanding of the system for regulated professionals, there should be standardisation across the regulatory bodies with regard to fitness to practise. The consultation

states that: "The proposals in this chapter are not dependent on the changes to either those groups that are regulated or to the number of regulatory bodies." Therefore the move to standardisation of process should move ahead to allow comparisons on a 'like for like' basis, and prior to decisions being made on number of regulatory bodies.

The RPS has received some evidence from some of its members that on occasion the GPhC is unable to act in a timely manner or apply appropriate sanctions - this could be harmful to patients and potentially harmful to the reputation of pharmacy as a profession as well. Any such powers must instil confidence that patients and other healthcare professions have in pharmacy. It is important that issues are dealt with and not 'parked' because a complex system inadvertently mean that roles and responsibilities are not clear with incorrect assumptions being made about which regulator should be resolving fitness to practice cases.

Q9: What are your views on the role of mediation in the fitness to practise process?

In theory a process of mediation would be helpful (if it is applied appropriately) as it may reduce the adversarial nature of the current process e.g. if performance has been affected by stress or poor management and it is followed up to ensure that the pharmacy professional /premises continues to improve. It might also be useful if unintentional errors have been made and there is no history of problems with the professional in question. However, careful consideration needs to be given as to when it is applied (in the interests of patient safety) and timeliness is of the essence to achieve early resolution of problems of fitness to practice.

Regulators applying a triage service should not permit mediation / dispute resolution (or any sort of investigation) to proceed as a way to keep complainants placated. The 'heads of complaint' must meet defined criteria for mediation / dispute resolution. The process would allow for any complaint to be dismissed (where the criteria are not met), proceed to mediation / dispute resolution or escalate to fitness to practise investigation. Certain issues (criminal) could move straight to fitness to practise with the potential to change to a more systematic approach, namely clarity from police on certain matters where suspension is advisable.

The process of triage for complaints and concerns from service users, with formal handover (not just simple signposting) to other processes such as dispute resolution and mediation, would seem to be an effective approach. However, any service will need to ensure there are robust processes for managing people with behaviour that is challenging (i.e. vexatious complainants) and that it is transparent and standardised across the regulators (currently and post any review).

Engaging with patient groups such as the Patients Association to a point of gaining endorsement guidance on mediation / dispute resolution would provide patients and service users with assurance that the process was not seen to favour registrants over patients / service users.

The quality assurance processes of investigations that do require the fitness to practise process must be transparent for public confidence, as well as providing confidence to registrants about value for money.

Q10: Do you agree that the PSA's standards should place less emphasis on the fitness to practise performance?

Yes	☒
No	☐

In seeking assurance from the oversight process the PSA should also consider other aspects of the registrant journey including education and revalidation.

Q11: Do you agree that the PSA should retain its powers to appeal regulators' fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

Yes	☒
No	☐

There should also be a process, standardised across the regulators and overseen by PSA, that supports the registrant appeal processes where determinations are perceived by registrant to be disproportionate. Interdependencies with system regulation would add robustness. For example in pharmacy any decisions to appeal decisions regarding a pharmacist in the role of the Superintendent Pharmacist would also need to prompt a 'system' review (where there are concerns).

There is more to regulation than fitness to practise. The regulatory system should also support the professional development of all registrants to ensure the workforce has the right skills and experience to deliver high quality care. This includes accrediting courses so that professionals receive good training and education that instil the right skills and behaviours to prevent problems occurring. It also means providing assurance that professionals' skills and behaviour remain fit for purpose throughout their career and supporting the development of a flexible workforce that is responsive to the changing healthcare needs of the population.

The 2007 Government White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* set out a number of key principles that should underpin statutory professional regulation. It stated that "professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour". Providing all regulatory bodies with powers to deal with fitness to practise complaints in a more flexible and proportionate way will enable regulators to free up more time to focus on supporting registrants to meet and maintain their professional standards.

Q12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?

The GPhC has a role by ensuring that accredited initial education and training includes professionalism and that revalidation processes continue to support it so that the right people enter the register and remain registered. If this role is to deliver a greater focus on professionalism then all regulators should become more proactive with their approach. The role of the professional bodies such as RPS should be to develop its members beyond the minimum core standards set by the regulator through more detailed developmental standards and guidance. In many cases the RPS should advise the GPhC on professional practice. It is important that the scope of the role of the regulator does not drift into areas that are beyond their remit of patient safety.

The professional leadership bodies and regulators should consider working together to harmonise revalidation given the range of processes and differences across the healthcare professions - but there needs to be recognition that there are different types of requirements for those who deliver hands on procedural interventions as part of their care compared to knowledge only professionals. There should not be a requirement to demonstrate minimum levels of hands on clinical practice for

registration if their role does not require it i.e. it should relate to the scope of practice. Different levels of registration may be required to acknowledge this.

Efficient regulation

The nine UK regulatory bodies all carry out similar functions in relation to different professional groups but undertake these in different ways and under different legislative frameworks. Even without a reduction in the number of regulators there is substantial scope for sharing functions between regulators to deliver a more consistent and cost effective approach.

Working with the regulatory bodies and the PSA, the four UK governments have identified four potential areas where joint working may improve public protection and at the same time generate efficiencies:

- A shared online register, search engine or online portal of all registered healthcare professionals. This will make it easier for patients, the public and employers to access details about whether a health professional is registered and about that professional's registration;
- A single set of generic standards for all healthcare professionals (underpinned by profession-specific standards owned by the individual regulators). This will ensure that all health professionals are working to the same core set of professional standards. The standards will only differ where there is a profession specific need. This model has been successfully operated by the HCPC for many years;
- A single adjudicator responsible for all fitness to practise decisions. This will provide greater consistency of decision-making on all fitness to practise cases, making the process fairer for regulated professionals and for patients and the public. This could build on the Medical Practitioners Tribunal Service which considers fitness to practise cases brought by the GMC; and
- A single organisation conducting back office functions such as HR, finance and IT. Each regulatory body is currently responsible for their back office services. If one organisation was responsible

Q13: Do you agree that the regulators should work more closely together? Why?

Yes	☒
No	☐

There is commonality of purpose and regulation should be fair across all professions. For the public, it would be easier for them to navigate the system. Currently it seems confusing for a member of the public about who they should submit a complaint to. If there is a single point of contact for complaints for the public it should be adequately resourced.

Also, by regulators working more closely together, registrants can be reassured that complaints are investigated and sanctions imposed in a consistent manner regardless of the profession. Currently there is a perception that sanctions vary between regulators for similar complaints. There would be greater transparency and understanding for registrants, the public and employers. Eliminating duplication will result in efficiencies and mitigate the risk of the system being 'played'.

Q14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

Shared online register
In principle this is a useful approach providing terminology is absolutely clear, explained and consistent. For instance, explaining annotations to registered professionals such as independent prescribing. It should be made clear which healthcare professionals can be searched for and which are excluded (signposts given for searching accredited healthcare workers).

A single set of generic standards
This will provide consistency and work is already underway. There needs to be co-ordination with Fitness to Practice (FtP) processes as these reference professional standards.

A single adjudicator for FtP
If set up properly this could provide more of a consistent approach. However, there would still need to be registrant members involved in panels and legal advisors / case presenters familiar with the relevant regulations.

Shared services model
Experience of implementing shared services in the public and private sectors over the years has demonstrated that this is usually difficult to achieve and has not always demonstrated value for money – particularly with the standardisation of IT systems. However, it would seem sensible to consider this once the final number and function of regulators is known.

There is a vast amount of intelligence gathered across the system but this is not systematically shared between regulatory partners to ensure that the right body takes the right action at the right time.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

Yes	☒
No	☐

The professional regulator should be at the centre where a registrant is involved, with other agencies feeding in.

It is right that the powers and remit of the regulatory bodies are set in legislation. However, the legislation has been developed over many years and still frequently needs to be amended. Changes to the operating practices of the regulators often require an amendment to primary or secondary legislation. DH views this as costly and time consuming. Where there is a public safety element the time taken to make these changes can compromise public protection.

Providing the regulatory bodies with powers to amend their own procedures would enable them to respond to the changing way that healthcare is delivered without requiring ongoing legislative intervention by government. In taking forward reform of professional regulation DH proposes to provide regulators with more flexible legislation that will allow them to set more of their own operating procedures.

Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

Yes	☒
No	☐

This will require robust governance, especially in ensuring fairness and consistency between the remaining fewer regulators. Provided that the operating principles are clear so that all registrants cases are fairly and consistently managed - the SOPs will reflect this and enable regulators to come to the same conclusion for like-for-like issues.

The PSA will continue to contribute to the accountability arrangements of the regulatory bodies in that it will continue to report to Parliament on their performance and through appearances before the Health Select Committee. The UK Parliament will continue to hold to account the PSA and the regulators covering the whole of the United Kingdom. The Northern Ireland Assembly will still hold to account the Pharmaceutical Society for Northern Ireland. Moving forwards the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly may also want to hold hearings or take evidence from the regulators and/or the PSA about the impact of their work in that jurisdiction. In addition the regulatory bodies should lay copies of their annual reports, potentially country specific, before all of the UK countries in which they operate to improve their accountability to each legislature.

Q17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

Yes	☒
No	☐

There is a risk that this approach will add more bureaucracy and cost to the functions of the regulators (and potentially registrants). There should be a consistency in accountabilities across the devolved administrations to ensure the regulators are not required to report differently in different countries. The oversight by UK Parliament should be reduced proportionately in line with principles of right touch regulation.

It could also be argued that patients' and professionals' needs do not change based on where they live and this approach could fragment regulation without improving patient safety. However, each devolved nation operates a different healthcare system so they are well placed to consider systemic approaches to patient safety.

The four UK governments believe that it is time to take the next step in the journey away from self-regulation and to explore a modernised governance structure for the regulators. This would involve the establishment of a new board structure which comprises both non-executive and executive directors. The non-executive directors, including the chair, would be selected to ensure that there is the right mix of skills and experience to ensure the regulator is robustly scrutinised. The distinction between representative and public members would be removed, although it would be extremely likely that the non-executive members would include people who are in the professions regulated, but these would not form more than half of the Board. The non-executive members would be appointed by the Privy Council as they are now to ensure independence from government.

Q18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

Yes	☐
No	☒

We are not convinced that this proposal will improve patient safety or promote professionalism. Indeed it could shift the focus away from these areas and disproportionately concentrate on organisational performance.

To support consistency, in moving to the new board structure we suggest that a tool / framework be devised to support board reviews. Any future rationalisation of regulators may mean a further review to ensure that the right mix of skills and experience were on the relevant Boards - a consistency in review process would support how boards are performing in the new structure.

To provide assurance of independence, the majority of the members of council should be lay members.

Q19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

Employers' priorities are frequently different to from those of professionalism and fitness to practice therefore a balance between employers, registrants and lay members' views would be sensible. Although the views of 'employers' are important in the regulation of health and care professionals, it is essential to recognise that this does not necessarily mean that they should hold places on the councils – hearing how regulation and professionalism impacts on the workplace can be covered in other ways e.g. consultations, focus groups etc. Indeed different employment models are in operation (some of these do not come under the remit of system regulation). Conflicts of interest will need to be carefully managed.

Q20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

Yes	☒
No	☐

Proposals should be in a standard format so that they are easy to view and compare. There should be continuity and cross-working e.g. regulators should observe other regulator's fitness to practice hearings.

The four UK governments have been clear that fee rises should be kept to a minimum. This continues to be our position. Reform of professional regulation is likely to deliver more efficient regulation and there is a case for passing on at least some of the savings to registrants in the form of lower fees, in addition to investing in work to support professionalism.

Q21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

The implementation of the proposed changes is likely to increase costs in the short term, particularly for the PSA. Medium to long term savings could be used to reduce registration fees or to support professionalism e.g. in accrediting education providers or to provide further annotations on the register. Consideration should be given on the unintended consequences of impact on professional leadership bodies in terms of costs.

Impact Assessment

DH expects the impacts overall will be positive and deregulatory to business. The impacts of amending the legislative framework are expected to fall on a wide range of stakeholders including: the existing healthcare professional regulators; the PSA which oversees the activity of the regulators; the regulators' registrants (a proportion of whom undertake the majority of their professional activity in the private sector and therefore are classified as businesses); patients; the wider public and government. Most of the costs and savings will impact on the regulatory and wider healthcare sector.

Q22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?
- an increase
- a decrease
- stay the same
Please explain your answer and provide an estimate of impact if possible.

This is difficult to assess because improved patient safety and improved quality of care have not been quantified in the consultation document. In addition, the drawbacks to the proposed changes are only expressed by a single term.

Q23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

The proposals have the potential to contribute to improved public protection and patient safety by reducing barriers to innovation and by increasing opportunities to focus on professionalism and behaviours for safe working. There is much implied within the consultation and further tangible benefits would need to be described. The initial focus on efficiencies does provide opportunities although the patient safety (health benefits) need further articulation for public communications.

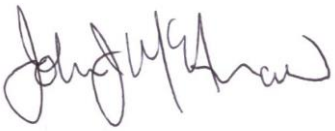
Equality Analysis

The Department of Health, the Devolved Administrations and the professional regulatory bodies are covered by the Equality Act 2010 and specifically the Public Sector Equality Duty. The Duty covers the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex and sexual orientation.

Q24: Do you think that any of the proposals would help achieve any of the following aims:
- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?
- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?
- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?
If yes, could the proposals be changed so that they are more effective?
If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?

We would expect that these proposal would have be neutral to the achievement of the aims of the Equality Act

Yours sincerely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