Paper PROLOG 1/2

Pharmacy Regulation: now and looking ahead

Purpose
This paper provides an overview of the main legislation governing regulation of pharmacists and pharmacy technicians – the Pharmacists and Pharmacy Technicians Order 2007 – and its implementation. It also looks briefly at other legislation governing pharmacy regulation and the factors to be considered in developing the legislative framework for the General Pharmaceutical Council.

1. The RPSGB's statutory functions

1.1 Uniquely among the health professional regulators, the RPSGB has a statutory enforcement role as well as regulating pharmacy professionals. The Society's statutory functions concern the regulation of professionals, pharmacy premises and medicines. This includes functions relating to corporate bodies. To enable it to discharge its broader statutory functions, the Society employs a team of inspectors. Further information on the Society's statutory functions is given below.

2. The Pharmacists and Pharmacy Technicians Order 2007

2.1 The Pharmacists and Pharmacy Technicians Order 2007 (P&PTO) has overhauled and modernised pharmacist and pharmacy technician regulation, replacing the outdated provisions of the Pharmacy Act 1954. The P&PTO strengthens and clarifies the Society's powers to protect, promote and maintain the health and safety of the public. The Order provides a comprehensive framework covering regulation of the two professions which is harmonised with the regulatory frameworks for other clinical professions such as medicine and dentistry.

2.2 The P&PTO is built upon an underlying policy of team regulation. Other support workers in the pharmacy team are partially regulated through pharmacists by means of standards for training and requirements for standard operating procedures.

2.3 The main effects of the Order are:

- Improved capacity to address fitness to practise issues, including health
- Reform of the Society's registration process
- Updated provisions for education, training and continuing professional development (CPD)
- Statutory regulation of pharmacy technicians in England and Wales.

2.4 The Order was developed as a result of close co-operation between the Department of Health, the RPSGB and the devolved administration health departments.

3. Fitness to practise

3.1 The reform of this area of the Society's work under the P&PTO was much needed. The powers of the Society's former Statutory Committee (disciplinary)

were almost "all or nothing" - it could only issue a reprimand/admonishment or remove someone from the register.

3.2 The Order sets out the Society's powers much more clearly than before. The Society now has three statutory fitness to practise committees: Investigating, Disciplinary and Health. In common with other reformed health professional regulators, the Society can now exercise a wider range of sanctions including suspension of registration and the imposition of conditions, such as restrictions on practice, upon registration. It also has the power to look at deficient professional performance (as distinct from misconduct). This enables a more nuanced approach to each case, benefiting the public and the profession.

3.3 The other principal development in this area is the introduction of a Health Committee. Previously, someone whose fitness to practise was impaired by ill-health had to be dealt with through the Society's disciplinary processes, which were designed to cope only with misconduct. The Health Committee is supported by clinical advisers and has powers to impose conditions or, if necessary, suspend registration.

3.4 An analysis of the Society's fitness to practise statistics compared with other regulators (NMC, HPC, GOC) indicates that it receives more allegations per registrant than some other regulators: 1.7% for the RPSGB compared 0.6% for the GOC or 0.2% for the NMC and HPC. This may be due to the context within which pharmacy - particularly community pharmacy - is practised: frequent financial transactions, easily verifiable mistakes and lack of alternative complaint routes. However, as a proportion of the registrant population, there are similar rates of referral of complaints to the adjudication process (range is 0.08% for the NMC to 0.14% for the RPSGB). The percentage of registrants removed as a result of the adjudication process ranges from 0.007% (HPC) to 0.25% (NMC). The RPSGB is in the middle of the range at 0.17%.

4. Education and registration

4.1 The P&PTO also updates the Society's registration provisions and provides for statutory committees dealing with Education, CPD and Registration Appeals. Additional detail on the Society's registration function is available in the *Your Register* report on the Society's website: http://www.rpsgb.org.uk/pdfs/registersreport06.pdf

4.2 The P&PTO clarifies and gathers together in one place all the Society's powers with regard to pre-registration education. In the past, there has been some confusion and occasional challenge about the extent to which the Society's powers with regard to pre-registration education derived from the Society's Charter or the Pharmacy Act 1954. One of the key aims of the Society's reform programme has been to avoid such confusion in the future by ensuring that all regulatory functions, powers and duties are covered in legislation and that the Society's internal administration and professional functions are covered by the Charter. This should provide a good basis for the transition to a General Pharmaceutical Council (GPhC) and a professional body.

4.3 The Order divides the Society's registers into practising and non-practising parts and introduces mandatory CPD for those on the practising registers. This means that a person will have to keep up CPD in order to practise.

4.4 The Order also makes provisions for annotating the registers to denote specialisations or advanced practice. These will allow the Society to decide what training is necessary, and who has undertaken it satisfactorily, and to annotate the register accordingly.

4.5 The pharmacy undergraduate degree is four years in length, culminating in an accredited MPharm degree which secures entry to the final pre-registration year. During the pre-registration year, training programmes are work-based with completion of a portfolio and assessments by tutors. The Society approves tutors, premises and programmes. The registerable qualification – MRPharmS – is awarded upon satisfactory completion of the portfolio with sign-off by the tutor and passing of a national registration examination which is governed by an independent Board of Examiners. Under the P&PTO, the Society has a duty to accredit MPharm programmes across the UK.

4.6 The Society accredits Overseas Pharmacists' Assessment Programmes (OSPAPs) and two-year Foundation Degrees in Pharmacy, which provide entry into Year 2 of an MPharm programme. The Society also accredits courses equivalent to S/NVQ2 qualifications and the underpinning knowledge requirements for the Medicines Counter Assistant qualifications. Whilst there is no statutory registration of these staff, employment and training is, as indicated above, regulated through pharmacists.

Education & Registration facts & figures

Accredited MPharm Programmes:	17 in the established UK schools
New MPharm programmes:	Currently taking students: 6 new schools Not currently taking students: 5 new schools
OSPAPs	4 accredited
Foundation Degrees (FDSc)	1 accredited
Pre-registration students (2006):	1,800 (includes 129 overseas non-EU applicants)
Approved pre-registration premises: (2006)	circa 3,000
Students in Yr 1 (2006):	2,761
Total no .of students (2006)	9,500 in 21 schools of pharmacy in UK
Prescribing courses accredited:	36 in total 35 Supplementary prescribing (4 with Ind. prescribing conversion courses) 1 Independent prescribing course
Qualified prescribers:	1,252 supplementary prescribers and 130 independent prescribers
Registered pharmacists (July 2007):	46,938 (including 8,337 non-practising)

Pharmacy Technicians on the voluntary register (July 2007): 5,785

5. Regulation of pharmacy technicians

5.1 The other major change stemming from the P&PTO is the statutory regulation of pharmacy technicians. Technicians are an important group who perform a growing range of tasks, including clinical work, hence the requirement for their statutory regulation. Pharmacy technicians generally work in teams with just one other main group - pharmacists - to common expectations and sharing a common ethos, so regulation with pharmacists is the best way to recognise this.

5.2 The P&PTO relates to Great Britain for pharmacists but to England and Wales only for pharmacy technicians. However, Ministers have announced that an amending Order is planned, to be brought into force by April 08, which will extend pharmacy technician regulation to Scotland. The bringing into force of the provisions in the P&PTO that relate to pharmacy technicians has accordingly been delayed until this amending Order is made, so that pharmacy technician regulation can be brought in across Great Britain at the same time.

5.3 A voluntary register of pharmacy technicians has already been created. Entry to the Register of Pharmacy Technicians will be based on award of an accredited S/NVQ3 qualification. Grandparenting arrangements are now in place to allow entry to the voluntary register.

6. Implementation of the Pharmacists & Pharmacy Technicians Order

6.1 The P&PTO's provisions are being brought into effect through detailed rules (statutory instruments) made under the Order. Like other regulators, the Society is implementing the Order in a phased programme:

- Phase 1: Registration, Fitness to Practise & Committee Rules (2007)
- Phase 2: Education, CPD & Committee Rules (2008)
- Phase 3: Pharmacy Technicians (2008)*
- Phase 4: Revised standards for performance assessment in fitness to practise (2009)
- Phase 5: Advanced/specialist practice, re-certification & re-licensing (2008/9)
- Phase 6: Fitness to Practise – Performance Rules (2009)

** Depends on making of the s60 Order to extend regulation of pharmacy technicians to Scotland.*

6.2 *Phase 1: Registration, Fitness to Practise and Committee rules*
Many of the P&PTO's provisions came into force on 30 March 2007. This allowed the first set of rules to come into effect, establishing the framework for the following committees to operate from April 2007:

- Investigating Committee
- Disciplinary Committee
- Health Committee
- Registration Appeals Committee.

6.3 The rules also set out the framework for ways of working in relation to both registration and fitness to practise. These arrangements ensure the proper separation between the setting of policy and standards and the application of

these in individual cases. The committees were recruited through an Appointments Group, set up as an arm's-length body, and were given a comprehensive training programme so that they could commence work as soon as the rules came into force.

6.4 Transitional arrangements apply to fitness to practise allegations under consideration by the Society when the new fitness to practise rules came into force. All allegations referred to the Statutory Committee before 30 March 2007 will be dealt with in accordance with the old rules by either the Statutory Committee or the new Disciplinary Committee. The transitional arrangements allow both these committees to hear cases under the old rules, so as to speed up the consideration of old cases in the system. The Statutory Committee will continue until all outstanding inquiries which must be dealt with under the old rules have been heard. Any allegation which had not been referred to the Statutory Committee by 30 March 2007 and all allegations received after that date will be considered by the new fitness to practise committees under the new rules.

6.5 *Phase 2: Education, CPD & Committee Rules*
These rules will reflect revisions to education and CPD functions and establish the framework for the Education and CPD Committees and the ways of working to transact, for example, the registration exam and pre-registration programme and the accreditation of programmes that lead to registerable qualifications and annotations. This will also allow the introduction of mandatory CPD for practising registrants. Drafting of Rules is now underway and recruitment and appointment of the statutory Education and CPD Committees is planned for 2008. The implementation of the Education and CPD rules will be important both for the RPSGB in fulfilling its current responsibilities and for the future GPhC. The introduction of mandatory CPD will be an important step towards building understanding of, and support for, revalidation within the profession.

6.6 In anticipation of the new powers and responsibilities and in recognition of the rapidly evolving clinical role of pharmacists, the Society announced a sweeping review of its education policy in 2005. This programme, Education Policy: Fit for the Future, is well under way and will lead in 2008 to the setting of a new range of standards to cover education, training and assessment up to and including the point of registration and the generation of proposals for further annotations to the register for advanced level and/or specialist practice.

6.7 *Phase 3: Pharmacy Technicians*
The drafting of amending rules and adjustment of committee and registration processes to accommodate statutory regulation of pharmacy technicians is the next phase of the implementation plan.

6.8 Initial steps are being taken to accredit the Technical Certificates which provide the knowledge components of the technician S/NVQ3 qualification in anticipation of statutory registration coming into effect in 2008.

6.9 *Phase 4: Revised standards for performance assessment in fitness to practise*
The implementation of revised education and fitness to practise standards to take account of performance will require revisions to the quality assurance processes in education and the drafting of new fitness to practise rules to reflect performance as well as health and conduct cases. Changes will also be

needed to guidance documents, indicative sanctions guidance and referral criteria. This will need to be accompanied by an ongoing training programme for staff, committees and their advisers.

6.10 *Phase 5: Advanced/specialist practice, recertification & relicensing*
The development of current advanced/specialist practice annotation policy to reflect a risk-based approach to regulation will be required. Amendment of the education rules to allow accreditation/approval of additional qualifications/ assessment processes at advanced level and development of the quality assurance infrastructure will follow. Development of recertification and relicensing policy & procedures; drafting of rules, establishment of processes and case management will all be required. Again, this will require ongoing training for staff, committees and their advisers and communications with all stakeholders throughout this programme of change.

6.11 *Phase 6: Fitness to Practise – Performance Rules*
The drafting of rules and the establishment of new FtP infrastructure to undertake performance assessments e.g. visiting performance assessment teams and local support networks. The current inspectorate arrangements are not set up to deal with performance cases; in the context of performance assessment, this will need to be reviewed. An external agency such as the National Clinical Assessment Service or the future professional body may undertake this work. There will be a requirement for guidance on how to deal with reports of performance assessors and, again, ongoing training for staff, committees and advisers. There are real difficulties in anticipating numbers of cases which may require performance assessment.

7. Other statutory functions

7.1 The Society's Inspectorate helps ensure that the Society fulfils its statutory enforcement duties and that professional standards of practice are maintained. In addition to enforcement duties under the Poisons Act, the Society has been given responsibility for enforcing many provisions of the Medicines Act 1968 relating to the retail sale and supply of human medicines and powers under the Veterinary Medicines Regulations in relation to the sale and supply of veterinary medicinal products from registered pharmacies. The inspectors also have a valuable proactive role providing advice and information to promote good practice and helping to avoid problems developing.

7.2 There are currently 24 pharmacy inspectors in Great Britain, all of whom are pharmacists with practical experience. Each pharmacy inspector is appointed under the Poisons Act 1972 and has responsibility for approximately 300–500 registered pharmacies. The Inspectorate operates a risk-based routine inspection process with the interval between inspection visits being informed by periodic declarations[1], self assessments, complaints data, local knowledge and intelligence and information from the statutory registers held by the Society. The inspectors monitor compliance with legal requirements and professional standards of practice and have an advisory and education role.

7.3 There are also 2 non-pharmacist inspectors, who investigate alleged criminal offences under the Medicines Act 1968 and alleged misconduct. All inspectors are authorised under the Medicines Act 1968 and the Veterinary Medicines

[1] The periodic declarations form part of the annual premises retention fee form

Regulations 2006. The Society's enforcement activity under the Medicines Act 1968 is not restricted to retail pharmacies and the Society's non-pharmacist inspectors routinely handle complaints about the sale and supply of restricted medicines from non-pharmacy outlets e.g. sales and supplies of Pharmacy only (P) medicines from garage forecourts, hotels and car boot sales.

7.4 The inspectors are unique amongst healthcare regulators, in that they undertake 'directed covert surveillance' within the meaning of s.26(2) of the Regulation of Investigatory Powers Act 2000. The Society is a 'relevant authority' for the purpose of s.28[2] of that Act. Such surveillance may be authorised only where necessary for the purpose of preventing or detecting crime, in the interests of public safety or for protecting public health. Recent inspections by the Office of the Surveillance Commissioner have commended the Inspectorate's work.

7.5 Activities carried out by the inspectorate include:
- Inspection of prison pharmacy services as part of HM Inspectorate of Prisons (England and Wales);
- Inspection of pharmacies in the Isle of Man (in agreement with the Isle of Man Government);
- Assisting with investigations into alleged misconduct by pharmacists residing in the Channel Islands;
- Medicine Testing Scheme and Market Surveillance Schemes (on behalf of MHRA);
- Drug Testing Scheme (Scotland only);
- Approval of new pharmacy premises.

8. Factors for the future

8.1 The P&PTO and the Society's implementation programme provide an excellent basis for the transfer to a GPhC. However, there are additional factors to consider if we are to ensure that the new legislation is fit for purpose from the outset.

8.2 There are some areas that the P&PTO does not cover. For example, the Society's Council made a number of recommendations to Government about improving the legislation relating to pharmacy premises, bodies corporate and the inspectorate but the Order doesn't cover these areas, because they fell outside the scope of a section 60 Order at the time that the Order was prepared. However, the scope of s60 Orders has since been amended by the Health Act 2006. There is therefore a need to clarify whether these deficiencies could now be covered in any s60 Order made to establish the GPhC or whether they should be addressed through another legislative route.

8.3 *Regulation of pharmacy premises, bodies corporate and superintendent pharmacists*

Adequate regulation of premises is required to minimise risk and improve the quality of goods and services provided from pharmacies. The current requirements for registration of premises could be improved to ensure adequate public protection. There are no meaningful criteria for registration. When conducting an inspection of new premises prior to registration, the Society's inspectors have no remit other than to ensure that the premises exist and are lockable so as to enable the public to be excluded. It may be argued

[2] Sch. 1, Pt II to the Regulation of Investigatory Powers Act 2000

that there is no need for further statutory powers in this area as the Society may specify professional requirements through its Code of Ethics but any attempt to use the Code of Ethics to enforce requirements in this area, where there could easily be statutory provision could seriously weaken the Society's ability to enforce standards. Whilst the Society has powers to deal, through its disciplinary processes, with cases where the public has been put at risk, there are no effective mechanisms for dealing with potential risks before harm has occurred. Indeed, the Society could develop and apply a set of standards at the point of application for registration of premises but, without effective powers, would not be able to prevent or revoke registered status once granted if premises failed to continue to meet standards. It appears that neither the Registrar nor the Minister has the power to refuse to register premises.

8.4 The legislation relating to the regulation of pharmacy premises and owners is antiquated and does not take into account the changes in pharmacy practice that have taken place. An increasing range of types of pharmacies now seek registration, including a number of pharmacies which are closed to the public. Registered pharmacies include 'hub and spoke' assembly factories linked to more traditional community pharmacies, internet pharmacies, manufacturing pharmacies, pharmacies using robotics and pharmacies where analysis of blood products is taking place. The bodies corporate covered by the Society range from proprietor pharmacists who have incorporated their businesses to large multinationals.

8.5 In addition, there are areas of the legislation relating to the registration of premises that remain unclear. Uncertainty remains over the Society's ability to register pharmacy premises that wish to operate mainly within the exemptions of s10 of the Medicines Act 1968 in order to avoid licensing requirements for the preparation, manufacture and assembly of medicines. The public (named patients) benefits from some of the pharmacy activities under s10 but the scale and range of activities being undertaken within the exemption of s10 was unlikely to have been anticipated when the legislation was drafted. While the complexity of the supply chain process has increased, regulation has been static.

8.6 The system of premises registration is extremely basic with an inflexible fee structure. The fee structure should better reflect the work involved e.g. levying a re-inspection fee should mean that well-maintained and professionally-run premises should not attract the same level of fees as those requiring frequent inspection. The Society wishes to ensure full cost recovery of its inspection and enforcement activities and to achieve an equitable balance between premises and individual fees which reflects the risks associated with both.

8.7 There are a number of loopholes in the system of registration of pharmacies. There are no provisions to prevent certain persons from owning a registered pharmacy. In the past, the Statutory Committee has taken decisions to strike off a pharmacist owner, who has subsequently changed the ownership of his pharmacy to a body corporate, appointed himself as a director and continued the business with little change. The public would not expect the regulatory body for a profession to permit such an arrangement, which may undermine confidence in the profession and the regulator.

8.8 Legislation dictates that a body corporate must appoint a superintendent pharmacist in order to comply with the requirements of a 'person lawfully conducting a retail pharmacy business' but the Society has no power to remove premises in cases where a superintendent pharmacist has not been appointed. The regulator's position requires strengthening in relation to superintendent pharmacists and directors of bodies corporate. There is no statutory time limit for notification of a change of superintendent pharmacist. This is a particular problem when a superintendent pharmacist resigns and the company fails to appoint a successor.

8.9 In some cases, a company will nominate a locum, with no real control over the business, as superintendent pharmacist of a body corporate and submit the relevant form to the Society. In all cases, the form must contain the signature of the nominated pharmacist, confirming that they have accepted the position. In the cases of 'locum' superintendent pharmacists, it is not unusual to find that they have resigned within a short timescale. In the past, prosecutions against companies have been dropped due to the fact that there was no superintendent pharmacist appointed at the time of the commission of the offences and the company has been dissolved by the time the case has come to court, which leaves no effective sanctions. The owners of the dissolved company can then set up a new company and carry on trading from the same pharmacy premises.

8.10 There is a need to ensure that, in all cases, the position and powers of the superintendent pharmacist are adequate to enable him to ensure good practice within the company. This may become increasingly important as pharmacy is practised in a wider variety of settings, such as supermarkets and GP surgeries. The arrangements for responsible pharmacists will need to accommodate clear accountabilities.

8.11 The Society would be pleased to provide detailed suggestions for improvements to the legislative framework governing pharmacy premises and bodies corporate.

8.12 *Student fitness to practise*
Student fitness to practise was identified in *Trust, Assurance and Safety*[3] as a growing area of concern as students may now be working with patients fairly early in their training. This is an important issue, given the growing clinical activity of pharmacists and pharmacy technicians.

8.13 *Workforce mobility*
Mobility and complexity are key features of the pharmacy workforce which may pose particular and specific issues for developing modern regulation in pharmacy. The Society's work with students indicates that current and emerging trends in relation to flexibility, part time working and high levels of mobility are likely to continue unless employment conditions change markedly. The high levels of mobility within community pharmacy are set against a private sector employment market that includes small businesses (very similar to GP practices); small family-run and medium-sized regional chains and large multinational plcs.

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[3] Trust, Assurance & Safety – the Regulation of Health Professionals in the 21st century; Ch 6, paras 6.6-6.7, p76. The Stationery Office, Cm 7013; Feb 2007

8.14 The implications of this for the approaches taken to, for example, revalidation, dealing with poor performance, and teaching, learning & assessment will need to be carefully explored in the context of scoping the regulatory burden going forward. Clearly, the nature of the risk will vary depending on context and it is assumed that this will drive decisions about methods of assessment used to underpin revalidation.

8.15 Relicensure may be based on the regulator examining a proportion of portfolios. Given the number of locums and self-employed pharmacists, it is anticipated that the development costs in pharmacy will be substantial.

8.16 *Education funding and infrastructure*
Funding for the various elements of education and training for pharmacists are fragmented; the undergraduate programmes are funded by Higher Education Funding Councils and are the responsibility of DfES and equivalents in the devolved administrations, whilst the pre-registration year is funded largely by the Health Departments from the global sum for community pharmacy contractors and the MPET levy for hospital and primary care. Currently, funding for all four years of the MPharm is Band B (laboratory-based) with none at Band A (clinical); this contrasts with the position in medicine and dentistry. As an example, if the basic HEFCE funding unit is 1, Band B has a multiple of 1.7 and Band A has a multiple of 4. Funding for the pre-registration year includes elements for salary and training in varying amounts depending on the sector. Technician training is funded by the employers as for other vocational qualifications.

8.17 Lord Carter's working party report[4] highlighted that the structure of pharmacy education is out of step, or subject to different mechanisms, when compared with other health professions and that consideration should be given to this if the pharmacy profession is to make its full contribution to clinical care.

8.18 Emerging issues include:

Undergraduate

- Lack of appropriate funding for clinical teaching and learning in the undergraduate programmes e.g. Band A Higher Education Funding Council funding for years 3 & 4 and MPET Levy money for clinical placements.

Pre-registration

- Lack of formal quality management systems for the pre-registration year – for example, there is no equivalent to the deanery infrastructure available to support delivery in pharmacy. In our education review, we are looking at this and other potential models to integrate quality management and quality assurance.

Academic workforce

- Academic workforce issues in both clinical teaching and mainstream posts funded by Higher Education Funding Councils e.g. PhD funding for pharmacists

[4] Report of the working party on professional regulation and leadership in pharmacy; Foreword; p5. Department of Health, May 2007

New practitioners

- Difficulties in maintaining mentoring and supervision of newly-qualified pharmacists, particularly in the independent and SME businesses, will need to be addressed as registration becomes more focussed on clinical as well as technical roles. The lack of preceptorship and formal clinical supervision will need to be addressed.

Developing clinical skills

- Developing clinical skills amongst the existing workforce, clinical networks, audit, research and teaching as well as CPD.

- A comparison of the structure and funding of clinical education in pharmacy in New Zealand, Australia and the USA and with other clinical professions in UK (medicine, dentistry and optometry) reveals significant differences which, given that GB is leading developments in clinical practice e.g. prescribing, are of concern[5].

Relicensing and recertification

- *Trust, Assurance and Safety* indicates that medical revalidation will have two components: relicensure for all doctors wishing to practise in the UK and specialist recertification[6]. Analysis of the current proposals for revalidation[7] suggests that recertification will be applied only to specialist (including general practitioner) doctors and not to other health professionals – this leaves a potential gap in revalidation for pharmacist prescribers and, going forward, the responsible pharmacist.

8.19 *Implementing 2005/36/EC and other future changes*
The P&PTO will be amended by the forthcoming s60 Order which will extend pharmacy technician regulation to Scotland and also by the anticipated DH and DfES regulations which will implement Directive 2005/36/EC, making provision for EU-registered practitioners to visit Great Britain as temporary service providers.

8.20 During the time that we will be working towards a GPhC, the Society will need to implement the changes mentioned above, while maintaining 'business as usual'. We will need to keep track of the cross-professional changes to regulation stemming from *Trust, Assurance & Safety*, flagging up where proposals may or may not be appropriate for pharmacy. For this reason, it is important that the Society contributes to the development of the Bill and all s60 Orders stemming from the White Paper which could impact on the RPSGB or the GPhC. The context will be shifting as we move towards the GPhC and it will be essential that the process is managed carefully if public protection is to be maintained and, where possible, improved.

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[5] Wright et al; 2007 Healthcare professional education & training: how does pharmacy in GB compare? RPSGB http://www.rpsgb.org.uk/pdfs/healthcareprofeductrainGB.pdf
[6] Trust, Assurance & Safety – the Regulation of Health Professionals in the 21st century; Ch 2, para 2.8, p32. The Stationery Office, Cm 7013; Feb 2007
[7] Partial Regulatory Impact Assessment; Trust, Assurance & Safety – the Regulation of Health Professionals in the 21st century; The Stationery Office, Cm 7013; Feb 2007

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Date submitted to the Department of Health: 27 July 2007