Meeting of the Council
Agenda

Thursday 12 September 2013
10.15am to 3.00pm

Hearing Room 1
129 Lambeth Road
London SE1 7BT

Enquiries: Paula Woodward
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Public business

1. Attendance and introductory remarks
   Bob Nicholls

2. Declarations of interest
   All

3. Minutes of meeting 13 June 2013
   Bob Nicholls

4. Matters arising
   Bob Nicholls

5. Strategic plan 2014-17
   Duncan Rudkin
   09.13/C/01

6. Mid Staffordshire Public Inquiry: update on key issues for pharmacy regulation
   Duncan Rudkin
   09.13/C/02

7. Further developing our approach to modernising pharmacy regulation
   Hugh Simpson
   09.13/C03

8. New inspection model
   Claire Bryce-Smith
   09.13/C/04

9. Registered pharmacies: update on guidance and Rules
   Hugh Simpson
   09.13/C/05
10. **Performance Monitoring**  
   For noting  
   09.13/C/06  
   Duncan Rudkin

11. **Professional Standards Authority performance review report 2012-13**  
   For noting  
   09.13/C/07  
   Duncan Rudkin

**Lunch**

12. **Revised learning outcomes for the initial education and training of pharmacists**  
   For decision  
   09.13/C/08  
   Nigel Clarke

13. **Chief Executive & Registrar’s report**  
   For noting  
   09.13/C/09  
   Duncan Rudkin

14. **Remuneration of Investigating Committee Chairs and Deputy Chairs**  
   For decision  
   09.13/C/10  
   Viv Murch

15. **Council and Committee schedule for 2014**  
   For decision  
   09.13/C/11  
   Matthew Hayday

16. **Direct Debit indemnity arrangements**  
   For decision  
   09.13/C/12  
   Bernard Kelly

17. **Any other public business**

**Confidential business**

18. **Minutes of meeting 13 June 2013**  
   Confidential session  
   Bob Nicholls

19. **Matters arising**  
   Bob Nicholls

20. **GPhC accommodation**  
   For decision  
   09.13/C/13  
   Bernard Kelly

21. **Remuneration Committee: unconfirmed minutes 25 June**  
   For noting  
   09.13/C/14  
   Liz Kay

22. **Audit and Risk Committee unconfirmed minutes 30 May**  
   For noting  
   09.13/C/15  
   David Prince

23. **Any other confidential business**

Date of next Council meeting  
14 November 2013
Minutes of the Council meeting held on 13 June 2013 at Novotel, Dickinson Street, Manchester, at 10.00am

Minutes of the public session

Present
Bob Nicholls – Chair Ray Jobling
Sarah Brown Liz Kay
Soraya Dhillon Berwyn Owen
Gordon Dykes David Prince
Mary Elford Samantha Quaye
Tina Funnell Keith Wilson
Mohammed Hussain Judy Worthington

In attendance
Duncan Rudkin (Chief Executive and Registrar)
Paula Woodward (Council Secretary)
Alison Readman (Interim Head of Governance)
Hugh Simpson (Director of Policy and Communications)
Bernard Kelly (Director of Resources and Customer Services)
Claire Bryce Smith (Director of Inspection and Fitness to Practise)
Vivienne Murch (Head of Organisational Development & People Strategy)
Jane Robinson (Head of Communications)
Lyn Wibberley (Head of Executive Office)

38. ATTENDANCE AND INTRODUCTORY REMARKS
38.1 The Chair welcomed members and staff attending the meeting. The Chair also welcomed the public observers.
38.2 There were no apologies.

39. DECLARATIONS OF INTEREST
39.1 The following interests were declared:
   - Item 17: Council appointments 2014
     Sarah Brown, Ray Jobling, Liz Kay and Gordon Dykes
- Item 20: MPharm accreditation report and decision
  Soraya Dhillon and Keith Wilson

40. MINUTES OF THE MEETING OF 11 APRIL 2013

40.1 The minutes of the meeting held on 11 April 2013 were agreed as a true record of the meeting, subject to the replacement of the word ‘prescribing’ with ‘dispensing’ in minute 5.2.

41. MATTERS ARISING

41.1 In relation to minute 21.1 Alison Readman (AR) reported that work to develop the behavioural framework had been completed and the framework circulated to Council members. The framework would be incorporated into the forthcoming performance review process for Council members.

42. PROPOSED LEGISLATIVE CHANGE FOR REGULATORY BODIES

42.2 AR introduced paper 06.13/C/01 which reported the Department of Health’s position on legislative changes for regulatory bodies.

42.3 The Council discussed public concern about the language skills of some healthcare professionals. Duncan Rudkin (DR) clarified why the government believed proposed changes to the GMC legislation could not be applied to the GPhC, namely the different way in which the wording of the two organisations’ respective legislation was framed. Hugh Simpson (HS) reported that the GPhC was working with other regulators to make representation to European institutions on the review of the relevant EU law, the Recognition of Professional Qualifications Directive.

42.4 In relation to the Council’s priorities set out in the paper at paragraph 1.1, DR reported that most of these would be covered by the Law Commission’s review of the regulation of health and social care professionals. DR also reported that it was hoped that the resulting bill would lead to greater consistency across the various regulatory bodies on matters such as fitness to practise.

42.5 The Council discussed the professional indemnity requirement set out at paragraph 2.4 of the paper. A member commented that there was no clear definition as to what constituted ‘practising’. DR reported that the intention was to ensure that indemnity covered activities where patient claims could arise.

42.6 The Council noted the paper.

43. MID STAFFORDSHIRE PUBLIC INQUIRY: UPDATE ON KEY ISSUES FOR PHARMACY REGULATION

43.1 DR introduced paper 06.13/C/02 and drew the Council’s attention to the draft policy statement set out in the paper at appendix 1. DR also reminded Council
members that the detail as to how the organisation would meet the challenges of
the public inquiry would be developed over the coming months.

43.2 The Council supported the thrust of the paper and the draft position statement.
During the discussion the Council noted that it was important to learn from near
misses as well as incidents, and that better understanding of the patient
experience, good and bad, was crucial to the development of improved services.

43.3 The Council noted the paper and agreed the position statement subject to
consideration being given to the inclusion of the following:

i. the ‘frontline practitioner’ and their professionalism

ii. the role of education and CPD

iii. transparency and the development of a culture where concerns
could be raised

iii. the core focus on patient safety

43.4 The Council also agreed that the Chair should approve the final version.

44. **ANNUAL REPORT AND ACCOUNTS - APRIL 2012 TO MARCH 2013**

44.1 DR introduced paper 06.13/C/03. DR reminded the Council that the annual report
document would only be made public after it had been laid before Parliament so
its contents should be treated as confidential until then.

44.2 Bernard Kelly (BK) drew the Council’s attention to the key points set out in the
external auditors’ key issues memorandum. BK reported that the issues raised
had already been dealt with or were being managed effectively and had not
given the auditors cause for concern.

44.3 David Prince (DP), Chair of the Audit and Risk Committee, reported that the
Committee had reviewed the annual report at its meeting on 30 May. DP
reported that the external auditors had not found any significant issues. He also
reported that the auditors had spoken to the Committee in private and had again
raised no issues.

44.4 During the discussion, the Council noted that the report was well written and
informative. A member commented that the ‘99% excellent’ figure in relation to
CPD (p22 of the annual report) would benefit from some wording to provide a
definition and some context. A number of other minor amendments were
suggested for clarity and consistency.

44.5 Responding to a member’s question on the diversity profile of those involved in
fitness to practise cases, Viv Murch (VM) reported that mechanisms were being
developed to ensure that these would be available in future reports.

44.6 The Council noted that a policy on the appointment of internal and external
auditors would be developed by management in due course and reviewed by the
Audit and Risk Committee.
44.7 The Council agreed the combined annual report, annual accounts and fitness to practise report for 2012-13. The Council also agreed that the Chair would approve any final amendments to the narrative text.

44.8 The Council approved the reappointment of the external auditors, Grant Thornton for the year to March 2014.

45. **DIRECT DEBIT INDEMNITY SCHEME SIGNATORIES**

45.1 Bernard Kelly (BK) asked the Council to agree to the withdrawal of the item from the meeting. On reflection and following discussions with the Chair of the Audit and Risk Committee, management would consider whether the requirements of the direct debit indemnity scheme could be provided in some other way.

45.2 **The Council agreed that the item should be withdrawn.**

46. **REVISED STANDING FINANCIAL INSTRUCTIONS (SFIs)**

46.1 Bernard Kelly (BK) introduced paper 06.13/C/05 by reporting that the Audit and Risk Committee had reviewed the revised SFIs at its meeting on 30 May 2013 and agreed to recommend them to Council for approval. He reported that the revised version incorporated an observation of the internal auditors regarding the number of tenders sought during tendering exercises.

46.2 **The Council approved the revised Standing Financial Instructions.**

47. **STATUTORY COMMITTEE PERFORMANCE MANAGEMENT**

47.1 VM introduced paper 06.13/C/06 by setting out the key findings of the external review. VM reported that, in conclusion, the review had found the processes to be sound and had offered some minor suggestions for improvement, such as refresher training and a review of the appraisal process.

47.2 During the discussion, some members suggested that a periodic external review, including examining a sample of hearings, would help the organisation take an objective look at its processes. This would be considered; however, the Council also noted that fitness to practise processes were already subject to external scrutiny by the Professional Standards Authority.

47.3 DR commented that a report would be presented to the Audit and Risk Committee in due course providing further information about implementation of the report’s suggestions.

47.4 **The Council noted the paper.**

48. **THE REMUNERATION OF ASSOCIATE WORKERS**

48.1 VM introduced paper 06.13/C/07 by drawing the Council’s attention to the key points, for example to the one-off increase from £223 to £300 for statutory committee members. The Council was informed that the figures set out in the
recommendations illustrated that current fees were falling behind those offered by comparator regulators.

48.2 Liz Kay, Chair of the Remuneration Committee, reported that the Committee had examined the matter in some detail at its meeting in April before recommending the increased fees.

48.3 The Council discussed the paper and noted that it was important to set fees at a level that would encourage high calibre candidates to apply. However, the Council also recognised that the higher level of fees offered might deter some individuals, particularly those who were qualified but who may view the role as a significant ‘step up’. VM reported that efforts would be made during any recruitment process to ensure that potential candidates were encouraged to apply, whatever their background.

48.4 VM reported that since the last Remuneration Committee meeting some internal anomalies had been identified such as those relating to Investigating Committee chairs and deputy chairs. This issue was being brought to the June meeting of the Committee.

48.5 The Council agreed that:

i. the fee for members of the GPhC’s statutory committees, Appointments Committee, Board of Assessors and accreditation teams should be increased by £77 from £223 to £300 a day;

ii. The fee for Fitness to Practise Committee and Registration Appeals Committee deputy chairs should be increased by £18 from £468 to £486;

iii. the fee for Fitness to Practise Committee and Registration Appeals Committee chairs should be increased by £6 from £583 to £589.

49. CHIEF EXECUTIVE AND REGISTRAR’S REPORT

49.1 It was agreed that this item would be taken out of turn.

49.2 DR introduced paper 06.13/C/08 which set out recent meetings and developments.

49.3 Regarding the Inspection Development Assurance Group (IDAG), DR reported that the first draft of the Rules had been shared with the Department of Health and that clarity regarding the timetable had been requested.

49.4 Regarding the Education Learning Outcomes Review Group, the Council asked that membership of the group be reviewed to ensure that there was pharmacy technician representation on the group as well as patient representation. Later in the meeting, Hugh Simpson reported to the Council that the group included a pharmacy technician and that a patient representative would also be included.
49.5 The Council expressed the view that as an organisation committed to involving patients and the public in shaping policy, groups such as this should always include patient and public representation unless there were good reasons not to.

49.6 The Council noted the report.

50. PERFORMANCE MONITORING

50.1 DR introduced the report (paper 06.13/C/09) by drawing the Council’s attention to some of the key points. He circulated a revised graph showing ethnicity profile statistics in place of that shown on page 15.

50.2 The Council requested that explanations for the delays for the older fitness to practise cases be provided in future (2.5 – 5 years), as previously requested in minute 9.3 of the April 2013 meeting. In relation to the fitness to practise figures, Claire Bryce-Smith (CBS) confirmed that all cases over 15 months were tracked meticulously. She reported that while there had been an increase in those cases, the majority of these were progressing towards a hearing with 15 out of 19 scheduled for a principal hearing. However, a small number of more complex cases remained. The reasons for the delays varied but could include third party involvement such as coroners’ inquests or the need for additional information from other organisations. She undertook to bring back the key messages of the Lean Review at a later date.

50.3 Responding to a question relating to the report on inspections, CBS reported that the new inspection model, with its associated information systems, would be introduced in the autumn. As data collected over time, this new system would facilitate more detailed analysis of inspection findings. In the meantime it was not cost-effective to provide a thematic analysis of the data.

50.4 With regard to complaints, it was agreed that rolling quarterly figures would be provided in future to complement the comparison with prior periods already provided.

50.5 In relation to financial performance, Bernard Kelly (BK) highlighted that the peak of cash at the end of the year was the result of the bulk of renewal fees being paid.

50.6 The Council noted the report.

51. STRATEGIC REVIEW OF RISKS

51.1 DR introduced paper 06.13/C/10 and reminded the Council that the corporate risk register was presented to the Council annually at the March workshop. Following discussions at the Audit and Risk Committee, the intention was to provide the Council with the risk register at an earlier stage in the annual planning cycle (eg November) so as to improve the business planning process and to give the Council more effective oversight.
51.2 DR reported that the Committee had noted a number of external risks, such as those relating to patient safety, that were not explicitly highlighted in the corporate risk register. As a result of these comments, consideration was being given to a thorough updating of the risk register to better reflect the organisation as it evolved from being a new entity (and so more concerned with internal risks) to becoming an established regulator focussed on external risks. The Council discussed the contribution it should make to this updating of the risk register. The Council noted that it was important for risks to be discussed openly so its presentation at a Council workshop was appropriate.

51.3 The Council commented that there were a number of projects coming up that were heavily dependent on the management team and suggested that risks around capacity should be more clearly expressed.

51.4 A discussion took place regarding whether the Council should see the risk register more frequently; however doing this would detract from the work of the Audit and Risk Committee. Furthermore, discussing the corporate risk register at meetings held in public might inhibit a full discussion of the risks. The Council also noted that the Audit and Risk Committee reviewed the corporate risk register at each of its meetings and therefore provided valuable oversight of the management of risks.

51.5 The Council noted the paper.

52. **Audit and Risk Committee Annual Report to Council**

52.1 DP introduced paper 06.13/C/11 by stating that the aim of the Committee’s annual report was to provide the Council with a number of key assurances. DP reported that the Committee had given some thought to the structure and content of next year’s report and it would flow from the Committee’s terms of reference. He also reminded the Council of the changes to the Committee’s membership over recent months.

52.2 In relation to internal audit, DP reported that the internal auditors provided a good level of assurance for a relatively new organisation with internal audit actions and management’s response tracked at each meeting. However, the Committee had noted that some timescales for completion of actions had proved to be over-ambitious and had been pushed back. Responding to a member question on the number of limited assurance verdicts given by the internal auditor, DP informed the Council that this was not an unusual result from an internal audit. The Committee had considered the issues raised and found that most issues were minor points and being dealt with effectively. However, where more substantial matters were raised, these were being dealt with through discussions between the internal auditors and the management, with oversight by the Committee. DP emphasised the Committee’s commitment to reviewing progress made by the executive, and challenging where required, in relation to the information security project.

52.3 The Council noted the report.
53. **UNCONFIRMED MINUTES OF THE AUDIT AND RISK COMMITTEE**

53.1 DP introduced paper 06.13/C/12 and informed the Council that it provided a summary of the discussions and decisions taken at the Committee meeting on 30 May 2013, since the minutes had not been ready when the papers had been circulated. Formal unconfirmed minutes of that meeting would be provided to the Council at its next meeting in September.

53.2 The Council noted the report.

54. **COUNCIL APPOINTMENTS 2014**

54.1 Sarah Brown, Ray Jobling, Liz Kay and Gordon Dykes declared interests in this item.

54.2 Judy Worthington (JW) introduced paper 06.13/C/13. She reported that the appointments procedure was currently under way. However, some concern had been raised about how the Council’s views as the client could be expressed given that no Council members sat on the Selection Panel. The Chair reminded the Council that he had announced his intention not to seek reappointment after the end of his current tenure. This removed any direct conflicts of interest and meant that he would be able to act as a link point between the Council and the Selection Panel. AR would also be the guardian of the process.

54.3 AR commented that the paper stated in paragraph 2.3 that the process had been approved by the Professional Standards Authority (PSA). In fact, the PSA had confirmed that it had no further comments on the process at that stage. The Council noted that scrutiny would continue in the usual way until the appointments process had run its course.

54.4 The Council noted the report.

55. **COUNCIL BUSINESS SCHEDULE**

55.1 The Council noted the business schedule set out in paper 06.13/C/14.

56. **ANY OTHER BUSINESS**

56.1 The Chair confirmed that the meeting was moving into confidential business since some matters to be discussed named individuals and were commercial in confidence.

56.2 There being no further business, the part of the meeting that was held in public closed at 2.10pm.

**DATE OF NEXT MEETING**

Thursday 12 September 2013
Strategic plan 2014-2017

Purpose

Recommendation
The Council is asked to agree the strategic plan which appears in draft at Appendix 1.

1. Introduction
1.1 We have to submit the strategic plan to the Privy Council Office for laying before Parliament and the Scottish Parliament.

1.2 In 2010 the Council agreed its original Vision and Strategy document – the core strategic document which committed the Council to developing a three to five year strategy for the future.

1.3 Council accordingly agreed a strategic plan for the period 2012-2015 in September 2011, and that plan was updated in September 2012, to cover the period 2013-16. This was in line with our statutory obligation to submit a strategic plan annually, to be laid before Parliament and the Scottish Parliament.

1.4 Whereas the drafting of the strategic plan agreed by Council this time a year ago involved only modest amendments to the plan agreed in 2011, our preparatory work this year has highlighted the need for a fresh look at the strategic plan, in view of significant developments in the environment in which we work. Accordingly, the draft strategic plan proposed in the paper is notably different in approach from its predecessors.

2. Key considerations
2.1 The strategic plan contains a high level explanation of the GPhC’s aims. As in previous years, the new strategic plan will be complemented by a more detailed corporate plan (due to be considered by Council at its meeting in February
2014). The strategic plan summarises what the organisation will be aiming to achieve. The corporate plan will set out how we plan to do that, and how we will report on progress.

2.2 If agreed by Council the proposed new strategic plan definitively marks the end of the GPhC’s establishment phase and signals a clear direction of travel for the future of pharmacy regulation.

2.3 The draft plan being proposed includes a clear rejection of what appears to the GPhC to be a false dichotomy between a narrow reductive vision of pharmacy regulation (exclusively concerned with enforcing “minimum standards”), on the one hand, and, alternatively, an expansive purposeful concept of pharmacy regulation, driving continuous improvement and culture change.

2.4 Instead, the draft plan is informed by the conviction that efficient and effective assurance of core standards is the foundation on which regulation must be built (if it is to protect the public and have credibility) and on that secure foundation the regulator has a duty and opportunity to use its regulatory levers strategically to play its part in promoting improvement - providing essential underpinning for public confidence in an increasingly wide and diverse clinical and public health role for pharmacy.

2.5 The proposed strategy is not a matter of personal preference on the part of our governing Council, but, it is suggested, an approach to pharmacy regulation dictated by (a) our understanding of the GPhC’s widely drawn statutory remit, (b) the changing nature of pharmacy and (c) by the health and wider societal context within which that change is taking place. Key aspects of this context are referred to in the draft strategic plan itself.

2.6 The establishment of the GPhC marked an important change in the governance of pharmacy regulation, with regulatory responsibility vested for the first time in an independent statutory body. The operation of regulation itself, however, was not changed in a fundamental way at that time, although important developments have been implemented subsequently, largely through incremental change. By contrast, the proposed strategic plan, if agreed, will require more fundamental and significant change to pharmacy regulation than the creation of the GPhC itself represented.

2.7 In particular, the proposed strategic plan calls (amongst other things) for

- A completely new form of interaction between the pharmacy regulator and the public who use pharmacy services;
- As part of that, a wholly new conceptual approach to our use of information provided by the public and by other bodies, moving away from seeing information as ‘complaints’ to be processed, towards a notion of sources of intelligence to be sought out, analysed and acted upon, to inform targeted regulatory action;
- A step change in the effectiveness of our strategic and operational collaboration with other regulators and with the providers and (where relevant) the commissioners of pharmacy care and services;
• A recognition that discharging our statutory functions in process terms (handling fitness to practise cases, for example, or accrediting pharmacy schools) is only half our job; the other half being about analysing and sharing the data and information which we derive from carrying out those processes, to improve our work continuously and as a unique and valuable database for use by those with responsibilities for organising and providing pharmacy care and services.

2.8 The implications of these changes for the GPhC organisation are hard to overstate. The organisation which was established in 2010 and has grown incrementally since is a long way from being set up to deliver on the ambitions set out in the draft strategic plan. Everything from culture to IT, and every key process, will need to be reviewed and, potentially, subjected to transformational change in order to create a GPhC able to operate in the way indicated in the draft plan. Our recent thinking and development work have been heading this way intuitively; the new strategic plan would confirm the direction of travel and crystallise the case for it.

3. Equality, diversity and inclusion implications

3.1 The capacity and capability building we will need to carry out in order to rise to the challenge of the new strategic plan will be instrumental in strengthening our ability to build the evidence base for our equality, diversity and inclusion work.

3.2 In particular, using data to understand the impact of our regulatory policies and procedures is a theme running throughout the strategic plan. In updating our Equality and Diversity Strategy in the light of the new strategic plan, and in developing the new corporate plan, we will have the opportunity to support and develop the work we have already begun to identify and tackle any differential impact of our policies on people with protected characteristics (including patients and service users, registrants, students and GPhC staff).

4. Communications implications

4.1 The strategic plan itself, once laid before Parliament and the Scottish Parliament, serves a formal communication purpose as one of the core documents by reference to which the Council will be held accountable. GPhC annual reports, as well as accounting for progress in terms of the corporate plan to which the report relates, will include an interim update on progress within each year towards the achievement of these longer term strategic objectives.

4.2 The strategic plan will also inform day to day operational and corporate communications, as an important source document, to be drawn on for authoritative information about the Council’s aims and priorities.

5. Resources implications

5.1 The detailed evaluation of the resource implications is under way and will inform the preparation of the new corporate plan, future budgets and our medium to
long term financial planning. Our initial assessment has highlighted a number of key areas in which the new strategic plan will pose a significant challenge.

Information technology

5.2 IT will be critically important in enabling the implementation of the new strategic plan. Essentially our current IT was designed to enable only the transactional side of our work (see bullet 4 of paragraph 2.7 above). As is well documented, it has very limited and unsatisfactory reporting functionality, with no potential to give us the sort of intelligence we will need to deliver the new strategic plan. Our existing IT change planning addresses our needs in this area.

Business processes

5.3 Although IT will be at the front of our minds when thinking about the data and intelligence needs thrown up by the new strategic plan, an even more fundamental issue is our processes (how our people go about their day to day work, including but by no means limited to how they use the IT). These too are basically designed to enable the transaction of regulatory decisions and actions, not the aggregation and analysis of the information captured within the processes. A considerable programme of work will be needed to review and where necessary change or create new processes to provide the material (data, intelligence and knowledge) that will be the lifeblood of the new strategic approach.

Capacity and capability

5.4 Across all parts of the organisation we will need to consider whether we have adequate levels and amounts of staffing, and the right skills. We have already identified a significant development need under these headings in relation to data analysis and statistics, business intelligence and knowledge management. We have an external consultancy project well under way to advise the executive on options for making an early start to address these particular capacity and capability gaps. Additionally we will need to build on our early experience with research, and our informal preliminary thinking about evaluation strategies for regulators, in order to ensure we develop well-founded answers to questions about the efficacy and impact of our work, and to demonstrate the value that pharmacy regulation offers.

Organisational development

5.5 We have made good progress with our current organisational development programme. We will need to re-scope and re-plan in this area to ensure that we have the right learning and development in place to support the new strategic plan, and to build the significantly different culture which will be called for.

Financial implications

5.6 All the factors outlined above will have financial implications. GPhC reserves are now at a level which the Council considers appropriate, relative to current costs
and risks. Our work on the financial implications of the new strategic plan, which will be coming to the Council in more detail in connection with the 14-15 budget and the new corporate plan, is being carried out on the premises that

- the reserves should not be regarded as the source of funding for planned changes driven by the new strategy, and
- on the assumption therefore that the Council will not ordinarily want to agree deficit budgets and
- the likely scale of the resource implications of the strategic plan is such that efficiencies alone will not free up adequate additional resource.

5.7 The implication of this is that additional costs linked to the implementation of the new strategy will be likely to require consideration of fee rises, which we should address in a planned way over a period of years.

6. Risk implications

6.1 Our risk management approach has always been to consider risks that could jeopardise the achievement of the Council’s objectives. Our risk assessment has therefore historically been linked to those objectives. A comprehensive re-assessment of strategically significant risks should be carried out in light of the proposed new strategic plan. This will be reported to Council in November, as part of the regular strategic review of risks item.

Recommendation

The Council is asked to agree the strategic plan which appears in draft at Appendix 1.

Duncan Rudkin, Chief Executive & Registrar
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27 August 2013
DRAFT

General Pharmaceutical Council
Upholding standards and public trust in pharmacy

Strategic plan 2014-2017
Foreword by the Chair and Chief Executive

We began work as the independent pharmacy regulator in September 2010. Our top priority in the first three years of our operation has been to ensure that we are delivering our core regulatory services efficiently and effectively. The work needed to do this has inevitably meant a lot of our energy has been quite internally focused. Since we began work the external context within which we work has changed hugely. We have seen

- major and ongoing change in how health services are organised throughout Great Britain
- the continuing steep rise in public expectations of what regulators can and should be achieving
- Robert Francis’s reports into the appalling failures at Mid Staffordshire NHS Trust, and related seminal reviews and reports including the Keogh review and the Berwick report
- the launch of a UK-wide programme to re-define the balance as between the scope of medicines legislation and statutory pharmacy regulation
- the challenges facing everyone working in pharmacy to make the very best contribution which pharmacy can offer to the health and wellbeing of people and communities.

This is our first fundamental review of strategy since the successful completion of our ‘set-up’ phase. In talking with our external and internal stakeholders and colleagues about the future strategy for pharmacy regulation we kept coming back to a few basic questions:

- Should pharmacy regulation be about assurance of ‘minimum standards’ or do we as the pharmacy regulator have a role to play in promoting improvement in standards and ultimately in health?
- How can regulation protect the public effectively without holding back pharmacy practice from developing dynamically and innovatively, which it needs to do in the public interest?
- Can we retain a clear focus on our core regulatory functions whilst serving a wider purpose?
- What does it mean to be proactive and ambitious as the pharmacy regulator, without fatally over-promising to deliver outcomes which are inherently beyond the reach of a body which must work within its statutory remit and functions?

This strategic plan gives our answers to these questions. Based on our experience of pharmacy regulation to date, and our engagement with health regulation more widely, our Council has formed a clear view that the GPhC must retain a relentless focus on our core regulatory functions and continue always to prioritise the effective and efficient delivery of our statutory duties. We have, equally clearly, rejected the notion that we must choose between this priority and an ambition to use regulation strategically as a lever for improvement in pharmacy. A ‘minimum standards’ or safety net approach to
regulation would not enable pharmacy to rise to the many challenges which rapidly changing medicines and modes of practice present, and to the varying types and levels of risk in pharmacy. At the same time, the public rightly has an expectation that the bar for entering and remaining within the profession is rigorously maintained. We believe regulation is about both maintaining that bar and using it to promote continuous improvement, on the part of individual professionals, the profession as a whole, and the registered pharmacies out of which professional services are provided.

We are one part of a complex system in each country of Great Britain for overseeing and improving the quality of pharmacy care and services. In all areas of our work we understand that effective joint working with partner organisations and other regulators is essential if we are to achieve what we have set out to.

We have a statutory requirement to submit our strategic plan to Parliament and the Scottish Parliament annually. We will therefore update the strategic plan each year. Our intention, however, is that our work for the next three years should be shaped by this strategic plan, so we currently expect to make minor changes only in each of the next two years.

Bob Nicholls CBE, Chair

Duncan Rudkin, Chief Executive

Our mission

Our statutory objective has been set for us by Parliament and the Scottish Parliament:

To protect, promote and maintain the health, safety and well-being of members of the public and in particular of those members of the public who use or need the services of registrants, or the services provided at a registered pharmacy, by ensuring that registrants, and those persons carrying on a retail pharmacy business at a registered pharmacy, adhere to such standards as the Council considers necessary for the safe and effective practice of pharmacy.

Our vision

Our vision is for pharmacy regulation to play its part in improving quality in pharmacy practice and ultimately health and well-being in England, Scotland and Wales.

What we do

We have these core functions:

- setting the standards of education and training which pharmacists and pharmacy technicians must meet in order to join our register and to remain registered throughout their professional life
• registering pharmacists and pharmacy technicians and setting the standards of conduct and performance which they must meet in order to stay on our register
• setting standards which must be met by the owners of registered pharmacies and the pharmacists who act as superintendents in company-owned pharmacies

• registering pharmacies which meet those standards and inspecting them to check that they continue to do so, as the services they provide and the environment within which they operate constantly change
• taking action when our standards are not met.

These functions are the essential levers available to us to achieve our aims. We understand that we need to carry out these functions efficiently and effectively so that we can also credibly make our contribution to improving pharmacy by

• using standards to ‘raise the bar’ over time to promote improvement
• making good use of what we learn about pharmacy from our core regulatory functions and what we learn about pharmacy from others
• speaking out to influence pharmacy, and pharmacy-related policy development, in line with our vision
• providing a regulatory framework within which professionalism can flourish.

Our key themes for 2014-2017

We will focus on four key themes:

1. proactive good quality regulatory services
2. putting people at the heart of what we do as a regulator
3. using the knowledge gained from our regulatory services and from our work with others in order to promote improvement in the quality of pharmacy care and services
4. promoting a culture of patient-centred professionalism in pharmacy.

Proactive good quality regulatory services

In the timescale covered by this strategic plan:

• Concerns about the fitness to practise of pharmacists and pharmacy technicians will be resolved safely, fairly and speedily, with 95% of fitness to practise cases concluded within 12 months.
• We will be making better links between quality assured information from different sources so that our regulatory interventions can be more effectively targeted.
• We will be using intelligence networks and effective operational partnerships with other regulators throughout Great Britain to identify and tackle issues and risks in pharmacy.
• The standards which pharmacies are achieving for and with patients will be measurably improved as a result of the information we share about our inspection findings.
• Our scrutiny of the quality of education and training will ensure that newly qualified pharmacists and pharmacy technicians are ready not just to play their part in protecting and improving people’s health and well-being when they start work but also to update and develop their knowledge, skills and practice as pharmacy continues to evolve.

Putting people at the heart of what we do as a regulator
In the timescale covered by this strategic plan:

• We will be reaching out to patients and carers – and their representatives and advocates – to support them in being well-informed and confident users of pharmacy services and to assist them in raising queries and concerns.
• All our regulatory policy development will have patient and service user involvement embedded throughout our process, from the outset through to implementation and evaluation.
• People who use services provided at registered pharmacies and by pharmacists and pharmacy technicians will be supported and enabled to share experiences and concerns with us to inform all aspects of our work.

Using the knowledge gained from our regulatory services and from our work with others in order to promote improvement in the quality of pharmacy care and services
In the timescale covered by this strategic plan:

• As well as using our regulatory levers to promote improvement in pharmacy, we will be using our securely held knowledge and information to improve our own work as the pharmacy regulator.
• We will be analysing data from our regulatory functions and critically scrutinising intelligence about pharmacy issues and risks, in order to keep our standards up to date, and to inform targeted regulatory interventions across all our areas of responsibility and then to evaluate their impact.
• We will be playing back to the profession and to pharmacy stakeholders the feedback we gather from people using pharmacy services, and from our assurance activities, to inform their work to improve quality in pharmacy.

Using regulation to promote a culture of patient-centred professionalism in pharmacy
In the timescale covered by this strategic plan:

• We will work with patients and other users of pharmacy services, and with pharmacists and pharmacy technicians and their leaders and
representatives, to build together a vision for patient-centred professionalism in pharmacy.

- We will ensure that this patient-centred professionalism is fundamental to
  - pharmacy education and training and to
  - the standards which we set for pharmacists, pharmacy technicians, pharmacy owners and superintendent pharmacists.

- We will strengthen the assurance we are able to provide as to the continuing fitness to practise of pharmacists and pharmacy technicians; our agreed vision of patient-centred professionalism will provide the core standard against which pharmacy professionals will be asked to give an evidence-based account of themselves and their practice.
Council meeting 12 September 2013

Public business

Mid Staffordshire Public Inquiry: update on key issues for pharmacy regulation

Purpose

To update Council on action being taken in response to the Francis report on the Mid Staffordshire NHS Foundation Trust.

Recommendations

The Council is asked to note this paper.

1. Background

1.1 This paper is to provide an update to Council on the approach and actions agreed at the April Council meeting earlier this year.

1.2 Council considered and agreed the following key themes as part of our response to the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust:

- Patient experience and patient voice
- Transparency (including data and information)
- Candour
- Whistleblowing
- Professionalism
- Partnership working and information sharing

1.3 Council agreed that the most effective way of ensuring the themes identified in our response to Francis were implemented would be by building them into the strategic and corporate planning processes and ensuring key elements were picked up in performance monitoring, avoiding the establishment of a specific ‘Francis Report ’ workstream. In addition, it was however agreed that a short progress report should be presented to Council to demonstrate relevant recommendations were being considered.
1.4 The annex to this paper is also intended to meet that commitment and highlight recommendations relevant to us within the Francis Report and draw Council’s attention to our approach.

1.5 The sections in the annex reflect the relevant chapters within the Francis Report and specific recommendations within those chapters are grouped and reproduced.

1.6 A brief overview of the GPhC response and related activity is provided under each set of recommendations.

1.7 It is our intention to provide a further report to Council in six months time.

2. **Our work to date**

2.1 The draft strategic plan 2014-17 has been drafted to reflect these themes as part of the organisation’s wider strategy.

2.2 We already have a significant programme of work underway to improve the regulation of pharmacies and pharmacy professionals which is consistent with many of the issues and recommendations within the Francis Report.

2.3 We are strengthening the work we are doing in developing and improving collaboration with other health and social care professional and systems regulators.

2.4 In addition, we will need to take account of any actions arising from the Government’s full response to Francis, due to be published in the autumn, the Berwick Review into patient safety, the work of the Rebalancing initiative and the outcome of the Law Commissions’ review of professional regulation.

3. **Equality and diversity implications**

3.1 There are no specific equality and diversity implications within this paper although individual strands of work included in the table at Appendix 1 will need to be considered for impact on equality and diversity.

4. **Communications**

4.1 There are no specific communications implications arising from this paper. A policy statement summarising the Council’s position in relation to the publication of the Francis report was published on our website in July.

5. **Resource implications**

5.1 There is a significant amount of work underway and planned associated with the themes and recommendations in the Francis Report. However, no specific additional workstreams or projects have been established in response to the report and no additional resources have had to be allocated.

5.2 Further consideration will be required by Council when considering the Budget for 2014/15 and the Corporate Plan later this year and in early 2014.
6. Risk implications

6.1 Two key risks have been identified with our response to the Francis Report. Firstly, that we fail to take proper account of the key themes and recommendations within the Report. We have mitigated this risk by reviewing the report, identifying themes and identifying how we will take these forward within existing or planned work. Scrutiny and assurance of this work will be carried out through performance monitoring and approval of the corporate plan.

6.2 Secondly a risk was identified that we develop a tick box process, reporting and auditing Francis related work. We believe this will also be mitigated by building this into performance monitoring and corporate planning.

Recommendations

The Council is asked to note this paper.

Hugh Simpson, Director of Policy and Communications

*General Pharmaceutical Council*

*hugh.simpson@pharmacyregulation.org*

*Tel 020 3365 3516*

*[Insert date of paper]*
Appendix 1

Key recommendations and GPhC view and activity highlights

Section: Responsibility for, and effectiveness of, healthcare standards

<table>
<thead>
<tr>
<th>Rec no.</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>24</td>
<td>Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals.</td>
</tr>
<tr>
<td>26</td>
<td>In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.</td>
</tr>
<tr>
<td>35</td>
<td>Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.</td>
</tr>
<tr>
<td>36</td>
<td>A co-ordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.</td>
</tr>
</tbody>
</table>

GPhC view and activity highlights

The broad thrust of these recommendations is consistent with the GPhC’s own regulatory standards policy. The focus on outcomes, and moving away from a checklist approach of process and procedures as part of our inspection model lies at the heart of our new inspection model. Our new inspection model reflects our desire, and the sentiments expressed in Francis, to move away from a regulatory model where checking compliance is the sole purpose.

The standards for registered pharmacies include a requirement for patients to be able to provide feedback and for that to be taken into account and action taken as appropriate. Evidence of pharmacies acting on patient views will be sought as part of the inspection process and we will continue to review how we can learn from the new model and enhance it during the prototype phase.
### Section: Responsibility for, and effectiveness of, healthcare standards

The need to identify opportunities to share information, both in terms of data, but also local informal intelligence is highlighted in the Francis Report. We have been working with key partners to build this into our IT and process modelling as we review our systems. We have established regular update meetings with Care Quality Commission and processes for information sharing; this is being developed into a formal Memorandum of Understanding. We also meet regularly to discuss complex policy and legal issues where there are, or have the potential to be, the need for joint assessment of organisations or providers registered with us both. Similar arrangements have been established with the MHRA.

As part of the prototype inspection model to be launched in November, work in the inspection team is already underway to consider how best to strengthen relationships with local organisations to understand and pick up local intelligence, including concerns raised by patients. Our directors for Scotland and Wales are also leading similar work with regulatory bodies and the NHS in Scotland and Wales.

The development of the new inspection model and improvements to fitness to practise will increasingly allow us to analyse data to consider what, if any, trends emerge as well as specific issues for concern either about a registrant or a premises. The capability to cross-reference and compare data between functions is a priority set out in the draft strategic plan.
### Section: Effective Complaints Handling

<table>
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<tr>
<th>Rec no.</th>
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<tbody>
<tr>
<td>109</td>
<td>Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.</td>
</tr>
<tr>
<td>110</td>
<td>Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.</td>
</tr>
<tr>
<td>111</td>
<td>Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.</td>
</tr>
<tr>
<td>112</td>
<td>Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.</td>
</tr>
<tr>
<td>113</td>
<td>The recommendations and standards suggested in the Patients Association’s peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.</td>
</tr>
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</table>

### GPhC view and activity highlights

Our standards for registered pharmacy premises set out a clear requirement that pharmacy owners and superintendents must ensure there are suitable mechanisms in place to enable members of the public, patients and staff to raise concerns. Concerns handled effectively by providers of services at a local level, as set out in the Francis Report, often provide the most effective resolution. A key element of the new inspection model is to examine and review how concerns are dealt with by registered pharmacies.

We are making it easier for people to raise concerns by improving the content of our website, creating online concerns forms and improving guidance around raising concerns. Some of this work has been initiated; other elements are linked to the introduction of new IT systems and applications software.
### Section: Effective Complaints Handling

We recognise that have much to do to improve our learning from data and information that we hold, including increasing the sophistication of our analysis of the source and nature of concerns and complaints raised with us. Improvements are being made to the way we categorise concerns at source with allegations tracked through to decision making to enable better analysis and insight to inform policy development.
### Section: Medical training and education

<table>
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<th>Rec no.</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>153</td>
<td>The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.</td>
</tr>
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</table>
| 155     | The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles:  
  - The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions.  
  - The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required.  
  - There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority.  
  - Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review.  

The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.  

All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value. |
| 156     | The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above. |
| 160     | Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns. |
## Section: Medical training and education

| 162 | The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed. |
| 169 | The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them and healthcare systems regulators. |
| 172 | The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient. |

### GPhC view and activity highlights

These recommendations with the Report highlight the critical role that education and training plays within the development of professionalism. The medical model of education and training, in the context of Mid-Staffordshire hospital, is very different to that of pharmacy. However, should the structure and funding of pharmacy education and training change as a result of initiatives such as Modernising Pharmacy Careers and equivalent initiatives in Scotland and Wales, we will need to build on work already underway to consider how we quality assure organisations which would carry out functions of a ‘pharmacy deaneries’ in the future. We are also considering how best to sharing information with key health education bodies in each of the three countries (including Health Education England, NHS Education Scotland and in Wales, the NHS Workforce, Education and Development Service.

Our core standards documents, including the student code of conduct and the standards for the initial education and training of pharmacists place patient safety at their centre. This includes the importance of raising concerns, an issue considered within the latest review out the education outcome standards where a new strengthened outcome has been proposed for consideration. We are seeking to learn more from data and information emerging from accreditation of pharmacy and pharmacy technician education, as well as pre-registration education and training.
Section: Medical training and education

Recommendation 172 in Francis highlights the issue of English language proficiency. We are seeking a s60 order to amend the Pharmacy Order to allow us to require evidence of the language competency of EEA applicants at registration and when concerns about fitness to practise are raised.

Section: Openness, transparency and candour

<table>
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<tr>
<th>Rec no.</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>173</td>
<td>Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.</td>
</tr>
<tr>
<td>174</td>
<td>Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.</td>
</tr>
<tr>
<td>179</td>
<td>“Gagging clauses” or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.</td>
</tr>
<tr>
<td>181</td>
<td>Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency. A statutory obligation should be imposed to observe a duty of candour:</td>
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<tr>
<td></td>
<td>• On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request;</td>
</tr>
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</table>
|         | • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is
Section: Medical training and education

- reasonably practicable.
- The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.

GPhC view and activity highlights

The GPhC recognises the importance of an environment and culture in pharmacy where healthcare professionals need to be open and honest with patients and the public and feel able to raise concerns with employers. These important themes are prominent in the new standards for registered pharmacies and the new prototype inspection model will provide a more robust process for checking whether concerns are indeed raised and acted upon. The GPhC has argued that the imposition of a statutory duty of candour on individual health professionals is not the most effective way to encourage the behavioural and cultural change we all wish to see. We have contributed information to the Professional Standards Authority’s review of the professional regulators’ work in this area. Their findings will inform our further discussions about what more we as the pharmacy regulator should be doing on this subject.

Separately, we have sought changes to the Public Interest Disclosure Act (PIDA) to amend the list of prescribed persons to which a worker may make a protected disclosure in the public interest. The changes, if approved, would include the GPhC along with the health and social care professional regulators.

The roll out of the new inspection model supports reinforcement of a learning culture through demonstrating learning from mistakes and feedback – near misses and dispensing errors, feedback and complaints from patients and staff.
### Section: Professional Regulation of Fitness to Practise

<table>
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<tr>
<th>Rec no.</th>
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<tbody>
<tr>
<td>222</td>
<td>The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.</td>
</tr>
<tr>
<td>223</td>
<td>If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.</td>
</tr>
<tr>
<td>224</td>
<td>Information sharing: Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.</td>
</tr>
<tr>
<td>226</td>
<td>To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.</td>
</tr>
<tr>
<td>229</td>
<td>It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.</td>
</tr>
<tr>
<td>230</td>
<td>The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.</td>
</tr>
<tr>
<td>234</td>
<td>Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.</td>
</tr>
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</table>
Section: Professional Regulation of Fitness to Practise

GPhC view and activity highlights

Our draft strategic plan sets out the importance we place on managing information and seeing concerns and complaints as a source of feedback to be considered both individually on their merit and also to be considered as a source of intelligence to be analysed and, where appropriate, acted upon.

Specifically the strategic plan recognises and reflects the themes- which we would support – set out in the section of Francis relating to fitness to practise. It identifies a need to make better links between quality assured information from different sources so that our regulatory interventions can be more effectively targeted. We will be analysing data from our regulatory functions and critically scrutinising intelligence about pharmacy issues and risks, in order to inform targeted regulatory interventions across all our areas of responsibility and then to evaluate their impact.

We are developing Memoranda of Understanding with key regulatory partners. However, we do not see these documents as central to information sharing, but a by-product. Far more important is to be able to demonstrate that information is shared, and that action is taken be it signposting or joint action, than simply having an agreement in place. This has includes NHS England and the NHS in Scotland where we have worked closely on specific cases and concerns where MOUs are in development, but not yet in place.
Section: Caring for the elderly

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<tr>
<td>242</td>
<td>In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.</td>
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</table>

**GPhC view and activity highlights**

Issues in relation to medicines management at ward level are principally a matter for NHS hospitals and their regulator, the Care Quality Commission (and equivalent bodies in Scotland, Wales and Northern Ireland). However, we do recognise that much needs to be done to encourage intelligence gathering about medication errors – both prescribing and dispensing – in pharmacy.

Our standards for registered pharmacy highlight this as an issue and our new inspection model is designed to encourage reporting and learning from errors.
### Section: Information

<table>
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<th>Rec no.</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>252</td>
<td>It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.</td>
</tr>
<tr>
<td>253</td>
<td>The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.</td>
</tr>
<tr>
<td>254</td>
<td>While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.</td>
</tr>
<tr>
<td>255</td>
<td>Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be made.</td>
</tr>
</tbody>
</table>

### GPhC view and activity highlights

*Using the knowledge gained from our regulatory services and from our work with others in order to promote improvement in the quality of pharmacy care and services is one of our draft strategic priorities for 2014-17.*

*Through the publication of inspection reports we will provide information for patient on expectations of the standards they should expect to receive from a pharmacy. Clear labelling of how well the pharmacy has met our standards will aid their understanding of standards and provide a clear picture of performance of the pharmacy.*

*Short term improvements to our IT system will provide the infrastructure for collecting evidence from inspections of registered pharmacy premises to inform future policy development, learning. We are also examining the ways in which we can analyse data across all our functions including inspections, fitness to practise, standards and education.*

*We are carrying out a survey of all pharmacy technicians and a large sample of pharmacists to gain a greater understanding of their roles and responsibilities to help shape how pharmacy and pharmacy regulation is carried out in future. Further quantitative research is also being planned in relation to assessing issues in pre-registration training of pharmacists and pharmacy technicians.*
Public business

Further developing our approach to modernising pharmacy regulation

Purpose
To update on the development of our overall policy and approach to the regulation of registered pharmacies.

Recommendations
The Council is asked to note this paper.

1. Introduction
1.1. When the General Pharmaceutical Council was established as the new independent statutory regulator for pharmacists, pharmacy technicians and registered pharmacies, regulatory functions were transferred from the Royal Pharmaceutical Society of Great Britain, but also new powers set out in the Pharmacy Order 2010 were conferred on Council, including a number in relation to registered pharmacies.

1.2. At various points since, Council has given clear direction to the executive of the GPhC in relation to the overall approach to regulation of pharmacies in general, as well as the specific approach to standards setting, inspection and approach to enforcement.

1.3. Further papers will be considered (09.13/C/04 and 09.13/C/05) which set out the next phase including the launch of the new inspection model from 4 November which will be run as a prototype, the publication of draft guidance, as well as an update on the public consultation on Rules which is required before we are able to use the full range of enforcement powers set out in the Pharmacy Order.
2. **Key principles and developments in health regulation**

2.1. At a generic level, Council has previously confirmed its desire for regulation of pharmacies to be consistent with both the principles of good regulation\(^1\) as well as the Hampton principles around inspection and enforcement\(^2\). More specifically Council has set out the underpinning principles for our work in this area which continue to provide the strategic framework for the development of our inspection model and approach to enforcement:

- **Outcome focussed standards:** Both our professional regulatory standards as well as our standards for registered pharmacies have been written in a way which describes what patients can expect and, where possible, the outcomes they can expect. Council’s view was that regulatory approaches based on lists of ‘input’ requirements, encourage a focus on compliance with Rules, rather than professional decision making.

- **Regulation which encourages professionalism:** Council has set out that it believes that pharmacy regulation, to be more effective in future, must encourage professional decision making where patient interests are put first and professionals are able, within a suitable framework, to make decisions appropriately.

- **Proportionality and risk:** We are committed to striking the right balance between the need for public protection and burdens placed on our registrants and on pharmacy owners. We will use the testing of the new inspection model and data we receive to further consider how we can use risk to inform our work in this area.

- **Protecting patients and encouraging improvement (and innovation):** The Hampton report, almost ten years old, focussed on approaches to encourage ‘voluntary’ compliance rather compliance through enforcement actions. The GPhC, like other regulators, has recognised that compliance based approaches tend to focus on a minimum bar and often encourages a culture of ‘teaching to the test’.

- **Our goal is not only to ensure all registered pharmacies meet our standards, but that we encourage improvement and high standards.** This approach is one that the Care Quality Commission is proposing to adopt, following public consultation, and in response to the independent inquiry into Mid-Staffordshire NHS Foundation Trust and Winterbourne View.

2.2. We recognised in our consultation document, *Modernising Pharmacy Regulation*, that by adopting the principles and approach set out above would

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\(^1\) [https://www.gov.uk/government/policy-teams/better-regulation-unit](https://www.gov.uk/government/policy-teams/better-regulation-unit)

\(^2\) [http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/budget/budget_05/other_documents/bud_bud05_hampton.cfm](http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/budget/budget_05/other_documents/bud_bud05_hampton.cfm)
require very significant changes to the historic ways in which the pharmacy regulator had operated. It would ensure a more appropriate balance as between the accountability of the pharmacist on duty and that of the people responsible for the ‘system’ in which the pharmacy operated – the owners and superintendents.

2.3. It would also require a wholly new model of inspection. Much of the feedback received in our first years of operation, both formal and informal, was that there was little clarity from those being inspected about the purpose of inspection. Despite evidence of high quality professional and regulatory interventions from inspectors, the feedback was that inspection was varied, lacked transparency, not quality assured in any meaningful way, and too focussed on narrow checks.

3. Recent external developments

3.1. It is important to recognise that since the publication of our new standards, the external environment has changed, along with public expectations in relation to the approach of regulators – particularly those in a health context.

3.2. The publication of the reports into Winterbourne View and the report from Robert Francis on Mid Staffordshire NHS Foundation Trust (considered in paper 09.13/C/02) both shine a light on a number of additional factors which we have sought to build into our policy development and inspection model. The need for transparency in our work, to encourage feedback from staff and from patients, as well as the need to promote a culture of candour within organisations are all themes which we have picked up and further developed.

4. Equality and diversity implications

4.1. There are no specific equality and diversity implications specific to this paper.

5. Communications implications

5.1. The consultation document, Modernising Pharmacy Regulation, set out the scale of change proposed in how pharmacies will be regulated in future. Previous Council decisions have endorsed the need to communicate extensively to ensure owners, superintendents and members of the pharmacy team are aware of the content of the standards for registered pharmacies, as well as the new accountability framework and approach to inspection.

6. Resource implications

6.1. There are no resource implications specific to this paper, although Council has considered previously both staff and other costs associated with the introduction of the new model of regulation for pharmacy.

7. Risk implications

7.1. There are no new risks associated with the content of this paper
Recommendations

The Council is asked to note this paper:

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23 August 2013
Public business

New inspection model

Purpose
To provide the Council with an update and assurance on the readiness of the new inspection model for the first stage of the nationwide rollout in November 2013.

Recommendations
The Council is asked to note:

i. the readiness of the inspection model for the first stage of the nationwide rollout in November;

ii. the aspects of the model which will be operational from November 2013 and further work required after that.

The Council is asked to agree:

i. provisional inspection labels for the outcome of an inspection for testing as part of the first stage of the nationwide roll out.

1. Introduction
1.1 This paper provides Council with an update and assurance on the readiness of the new inspection model for the nationwide rollout across England, Scotland and Wales beginning on 4 November 2013.

1.2 The paper has been divided into the following sections:

- Background to the development of the new inspection model to date
- Stage one nationwide rollout – what will be operational and further work required
- Key assurances underpinning the inspection model’s readiness for roll out
- Proposed inspection labels
2. **Background to the development of the new inspection model**

2.1 Since the approval of the new standards for registered pharmacies in September 2012, we have been developing the operational inspection model to provide assurance on how well the new pharmacy standards are being met.

2.2 The development has progressed with invaluable engagement from stakeholders, practitioners, patients and the public. This has been achieved through sounding boards of practitioners across England, Scotland and Wales, public and patient groups, stakeholder events, and one to one engagements. This early and on-going engagement has ensured feedback has been built in from the early design stages of the model’s development.

2.3 Scrutiny and assurance for the Council has been provided throughout by the Council member Inspection Development Assurance Group. The group has endorsed the overall approach and progress to date, whilst providing helpful constructive challenge. This has been in addition to Council workshops and registered pharmacies project updates to Council.

2.4 Inspectors and other key internal staff have been involved in the development of all aspects of the model through task and finish groups focussing on key work streams as illustrated below.

2.5 Appendix 1 provides a summary of the progress of these work streams to date.

2.6 Various aspects of the model continue to be tested and refined in readiness for the nationwide roll out. Action learning testing is being carried out in three phases. Phase one involved inspectors testing the inspection decision framework principle which they were involved in developing. They have also tested different approaches to risk assessment, pre-inspection preparation as well as the new application process for registering a new pharmacy premises. This phase has been completed.
2.7 Phase two testing recently concluded and covered inspections against all five principles of the new registered pharmacies standards and the preparation of test practitioner reports which have been subject to quality review.

2.8 Phase three testing will commence mid September to the end of October and will continue with on-site testing against all five principles as well as testing the improvement action planning for pharmacies with major or minor non-compliances (poor or satisfactory pharmacies – see inspection labels section) to ensure improvements are secured.

2.9 Feedback has continued to inform the development of the model, including feedback from the pharmacies involved in testing to date.

3. Nationwide roll-out

3.1 The inspection model is scheduled to be rolled out nationwide on 4 November. It will be run as a prototype from this date. This will enable us to use the new model to carry out live inspections across the country, while at the same time recognising that the model will need to be amended and improved in the light of our early experience and feedback. Although these will be live inspections nationwide (and therefore not fairly described as a pilot), the concept of prototyping the model helps to mitigate some of the risks associated with the Rules not being in place, and helps to explain why we are not intending to publish reports immediately.

3.2 The nationwide roll-out of the inspection prototype model will encompass the following areas:

- Registration of a new pharmacy premises
- On-site inspection
- Inspection reports and improvement planning for pharmacy owners and superintendents
- Quality assurance
- Interim IT system
- Strategic relationship management

3.3 The aspects of the model which are not scheduled for the nationwide rollout from November include:

- Publication of inspection reports
- Issuing improvement notices

4. Key assurances underpinning the inspection model's readiness

4.1 The following section provides additional detail in four key assurance areas for Council on the readiness of the inspection model for live use in prototype mode. These are set out as:

- delivering consistency in decision making;
- quality assuring inspections;
- key supporting infrastructure; and
• the Inspection Development Advisory Group

**Delivering consistency in decision making**

4.2 A number of measures have been developed to support inspectors in making consistent judgements. These include the inspection decision framework; high level questions and evidence bank; and quality assurance framework (next section).

**Inspection decision framework**

4.3 The inspection decision framework provides examples of the sorts of outcomes inspectors will be looking for underneath each standard. These are referred to as outcome indicators and are there to guide inspectors in making their judgements about how well the pharmacy has met the standards. These are not a ‘checklist’ to arrive at a particular overall label as a result of an inspection. They are indicative of the types of arrangements and outcomes that pharmacies might provide as evidence to demonstrate their performance against the standard.

4.4 The inspection decision framework sets out example outcome indicators for pharmacies performing at different levels against the standard. It does not seek to define example outcome indicators at the extremes. Threshold criteria have been developed and tested to help guide inspectors in judging a pharmacy as meeting the standard overall. There are no outcome indicators for an ‘excellent’ pharmacy as placing a pre-determined ceiling on innovation would be counterproductive.

4.5 The decision framework has been challenged by the sounding boards throughout its development, providing an invaluable reality check on the outcome indicators which sit within it.

**High level inspection questions and evidence bank**

4.6 Beneath the decision framework sits a guidance document which includes both high level inspection questions and an evidence bank for each standard. The high level questions are available for inspectors to use as a menu, rather than a script, to help elicit the evidence they need from a pharmacy to be able to make robust judgements. The evidence bank provides inspectors with examples of the types of evidence a pharmacy could draw upon to demonstrate how well it meets the standards. This could range from documentary evidence to reality checks and observations of activities in the pharmacy. This evidence bank was developed with the sounding boards.

5. **Quality Assuring inspections**

5.1 A three stage approach has been developed to quality assure inspections. This is based upon:

- investing in the skills and knowledge of inspectors;
- use of professional inspectors; and
• quality assurance reviews of inspection reports.

**Investing in the skills and knowledge of inspectors**

5.2 A populated skills and knowledge matrix for inspectors is in place, mapped against the new premises standards. All inspectors have been assessed against the skills and knowledge categories and a training and development plan is in progress for the priority areas identified prior to the piloting. This is being updated as the action learning testing progresses.

5.3 Stage one training has been completed. This covered risk management in multiples and independents and hospital pharmacy, new medicines service, medicines use review services and making judgements from observation. Stage two training covered feedback from stage one testing and learning and guidance and training on making evidenced based judgements.

5.4 Further training is planned for September and October covering areas identified from phase two action learning testing, training on tolerances, improvement action planning and approach and style of inspections.

**Use of pharmacy professional inspectors**

5.5 The inspectorate is currently comprised of 30 inspectors split between four regions, each headed up by a regional manager. Twenty eight of these are pharmacists and two are pharmacy technicians. A further recruitment exercise for an additional three inspectors is commencing in September 2013 to provide additional capacity.

5.6 We believe that the use of pharmacy professional inspectors adds value both to the quality and credibility of our inspections. Our new model places a premium on the professional judgement of our inspectors, within a quality assured framework. This is essential, given that our approach focuses on outcomes rather than process and checklists. As pharmacy professionals themselves our inspectors are able to interrogate assurance information provided by pharmacy owners critically but also empathetically.

**Quality assurance**

5.7 A quality assurance framework for the new model is in place and undergoing testing. This provides a sign off by regional managers before release of the draft report to the owner and superintendent.

5.8 A quality standard is in place setting out the quality expectations for inspection reports. The progress of inspectors’ performance against the quality standard is being tracked to inform team and individual training and development plans.

5.9 Inspectors’ test reports are already being assessed against this quality standard and strengths and areas for improvement identified. While this is a significant change in approach for inspectors they have risen to the challenge and there is clear progress as they gain more experience of working with the new model.
6. **Key supporting infrastructure**

6.1 An interim IT SharePoint solution to support the efficient operational delivery of the new inspection model is on track for the nationwide rollout. This provides an improved holding position between the obsolete current inspection system and the development of the integrated MS Dynamics CRM system for the GPhC. The latter will in due course benefit from the fine-tuning of the inspection model following the prototyping phase.

6.2 Inspectors have been actively involved in shaping the high level IT requirements to ensure the interim solution meets users’ and the organisation’s requirements. The first version has been tested by inspectors in August with wider inspectorate testing on track for September and October.

6.3 The interim solution is set to deliver an improved user interface that will enable an end to end inspection process to be delivered, providing more open and transparent information. Better management oversight is built in enabling more effective management of workloads and reporting capabilities. This will allow for analysis of inspection information. Importantly the system is being built flexibly so that it can be refined at minimal cost in the interim.

6.4 Some inspectors are currently testing the use of different IT hardware solutions for more efficient recording of evidence on site. These include an ipad, laptops and two different types of tablets. These will be evaluated in September.

7. **Inspection Development Assurance Group**

7.1 An advisory group comprising Council members and senior staff was established to provide scrutiny and oversight of the development of the inspection model. This has so far met on three occasions and has endorsed the overall development approach and monitored progress against key milestones and the mitigation of risks, whilst providing constructive critical challenge. The group has been invaluable in providing insights on such matters as stakeholder engagement; the inspectors’ skills and knowledge framework and ensuring the inspection model is flexible enough to accommodate different delivery models and the changing health landscape. At its last meeting in July the group reviewed the proposed changes to the inspection labels and considered these to be appropriate.

8. **Inspection labels**

8.1 As set out in the scene-setting paper on our approach to modernising pharmacy regulation, our goal is not only to ensure all registered pharmacies meet our standards, but that we encourage maintenance and improvement of high standards.

8.2 The inspection model plays an important part in achieving this goal by providing clear judgements on how well a pharmacy has met our standards. This provides assurance that risks to patient safety are being minimised and also importantly that better and innovative performance is recognised.
8.3 When we started developing the inspection model we were working to an overall binary judgement that indicated whether a pharmacy had met our standards or not. This would be followed by an additional descriptor about how well the pharmacy had met our standards – met minimum standards, consistently met standards well or exceeded standards. When a pharmacy had not met standards it either had minor non-compliances or major non-compliances.

8.4 The regulatory landscape has moved on since then including more recently the learning from Francis as well as our own perspective on our regulatory purpose. Our draft strategic plan signposts our desire to use our core regulatory functions to promote continuous improvement.

8.5 We are proposing to use the following judgement labels for a registered pharmacy premises inspection as part of the nationwide pilot:

- A poor pharmacy – has failed to meet the premises standards overall. It is likely to have major non-compliances against standards which indicate a moderate to high risk to patient safety. For example a major breach of one or more of the red flag standards.
- A satisfactory pharmacy – meets the majority of standards. Where there are minor non-compliances, these present a low risk to patient safety.
- A good pharmacy – meets all standards consistently well and can demonstrate positive outcomes.
- An excellent pharmacy – meets all standards consistently well and can demonstrate innovation in the delivery of pharmacy services.

8.6 Following action learning testing, this approach provides us with a clearer, simpler and more transparent framework for making judgements about pharmacies. This does not alter the content or format of the inspection decision framework developed to date, as it is primarily just a change in the description of the label used.

9. **Equality and diversity implications**

9.1 As reported in the separate paper on guidance and rules, an equality impact analysis will be prepared alongside the draft Rules and published as part of the supporting material for the Rules consultation. Separately we have carried out in-house an impact analysis on the inspection model itself, to inform our ongoing development work on the model.

10. **Communications**

10.1 A range of communications and engagement activities to support raising awareness of and positive engagement with the standards for registered pharmacies and the nationwide inspection pilot are planned. Key milestones, like the start of the national rollout, engaging on draft guidance, and the statutory consultation on the Rules, are shaping the timing of much of this activity.

10.2 These activities include updating our core messaging, continuing to push registrants (including owners and superintendents) to the standards, as well as
planning to attend a range of existing meetings and events, and organising a programme of our own meetings and conferences from November 2013 to April 2014. These will target patients and the public and their representative bodies, members of the pharmacy team, and organisations which represent the interests of the pharmacy team (e.g. RPS Annual Conference/Pharmacy Show/stakeholder and pharmacy network meetings).

10.3 We will be utilising the communications channels of those representative organisations, to supplement our own communications channels (website/social media/Regulate/Update/media). We are also introducing new products and activities, including a monthly bulletin for owners and superintendents, and use of distance learning techniques, like webinars and webcasts. The first issue of the new bulletin will go out in the third week of September, timed with the next issue of Regulate.

11. Resource implications

11.1 The development work is being resourced from our current establishment and budgets. The long term resource impact of the new model is being considered and will need to be informed by our experience during the prototyping phase. We know already that we need increased capacity to enable us to roll out the development of the new model.

11.2 The new reporting process will increase the time an inspector spends on each inspection as:

- Time spent on site will increase initially at least (as inspectors and pharmacy staff become more familiar with the premises standard and expectations, including the need to capture sufficient evidence for the new reporting process).
- In the new model, inspectors will be gathering and recording evidence on site which will be signed off by the Responsible Pharmacist. Subsequently, the inspectors will then review the evidence, write summary judgements and grade the performance of the pharmacy. There will then be a quality assurance process, which during the prototyping stage will be for all reports. This will inevitably increase time spent on each inspection.

11.3 As an interim measure we are planning to recruit three additional inspectors. We will continue to monitor the position.

12. Risk implications

12.1 There have been ongoing discussions with the Inspection Development Assurance Group regarding the risks relating to the new inspection model. Some of the salient risks are also being actively discussed and managed as part of the wider registered pharmacies work. The following are key risks that we will continue to monitor and take mitigating action where appropriate:

- The time and resource requirements needed to successfully operate a new model of inspection.
• The impact of the new regulatory requirements on owners and superintendents, and potentially the wider pharmacy team.
• An appropriate level of quality assurance to ensure consistency in application and robustness of the new model of inspection.
• Continued engagement, communication and consultation with stakeholders to ensure our key messages are clear and that the level of understanding regarding the standards and our approach is understood.
• The implication of sharing evidence and judgements in reports ahead of publication.

12.2 The action learning testing has already provided us with a good sense of the scale and importance of these risks and this report identifies many of the steps taken to mitigate risks as we move into the national roll-out phase.

Recommendations

The Council is asked to note:

i. the readiness of the inspection model for the first stage of the nationwide roll out in November;
ii. the aspects of the model which will be operational from November 2013 and further work required after that.

The Council is asked to agree:

i. provisional inspection labels for the outcome of an inspection for testing as part of the first stage of the nationwide roll out.

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22 August 2013
## Appendix 1

### Summary of progress of development work streams

<table>
<thead>
<tr>
<th>Work stream</th>
<th>Progress of actions for nationwide pilot</th>
<th>For action after rollout</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registration of new pharmacy premises</strong></td>
<td>- Two stage process developed – eligibility test and pre-registration standards visit &lt;br&gt; - Electronic application form developed &lt;br&gt; - Guidance for owners &lt;br&gt; - Tailored pre-registration on-site decision framework and inspector guidance and decision template &lt;br&gt; - Tested</td>
<td>- On-line form to be developed as part of MS Dynamics &lt;br&gt; - Finalise operational procedure &lt;br&gt; - Finalise guidance for owners</td>
</tr>
<tr>
<td><strong>Proportionate regulation</strong></td>
<td>- Headline approach to risk developed &lt;br&gt; - Pragmatic approach for piloting utilising: &lt;br&gt;  inspectors knowledge; and &lt;br&gt; available and accessible information from others &lt;br&gt; - Confidence rating post inspection developed and tested to inform inspection frequency</td>
<td>- Evaluation framework for the inspection service &lt;br&gt; - Confirmation of inspection frequencies</td>
</tr>
<tr>
<td><strong>Pre-inspection preparation</strong></td>
<td>- Information and tasks that could be reviewed or undertaken beforehand identified. &lt;br&gt; - Tested different ways of undertaking pre-site analysis</td>
<td>- Baseline data capture for existing registered pharmacies being considered &lt;br&gt; - Finalise guidance for inspectors</td>
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<tr>
<td>Work stream</td>
<td>Progress of actions for nationwide pilot</td>
<td>For action after rollout</td>
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<tr>
<td>On-site pharmacy</td>
<td>• Inspection decision framework developed with decision labels.</td>
<td>• Finalise inspection decision framework, high level questions and evidence bank</td>
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<td></td>
<td>• Example outcome indicators for standards in place for a ‘satisfactory’ pharmacy and a ‘good’ pharmacy.</td>
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<td></td>
<td>• High level questions and evidence bank in place to help support inspectors.</td>
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<td></td>
<td>• Criteria in place for what constitutes a major and minor non-compliance including identification of red flag standards informed by the sector that if not met indicates an unacceptable risk to patient safety.</td>
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<tr>
<td></td>
<td>• Extensive input from sounding boards</td>
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<tr>
<td></td>
<td>• Second stage testing complete, further refinement and testing continues.</td>
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<tr>
<td>Report writing</td>
<td>• Early engagement with public and patient groups on content and format of public summary report.</td>
<td>• Engagement and drafting of sample public summary reports with patient and public groups to re-commence in November.</td>
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<tr>
<td></td>
<td>• Report template for pharmacy owners and superintendents developed and being tested.</td>
<td>• Scoping of website content and publication process in development.</td>
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<td></td>
<td>• Engaged with practitioners to inform format and content.</td>
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<td>• Model inspection report guide for inspectors in place</td>
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<td></td>
<td>• Improvement action plan template developed and due for on-site testing September</td>
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<tr>
<td>Work stream</td>
<td>Progress of actions for nationwide pilot</td>
<td>For action after rollout</td>
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<tr>
<td>Quality assurance</td>
<td>• Quality assurance approach, process and standard in place</td>
<td>• QA step being built into interim IT solution</td>
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<td></td>
<td>• Test reports being quality assured and progress tracked</td>
<td>• Internal audit of design effectiveness health check of QA approach scheduled end September.</td>
</tr>
<tr>
<td>Publication</td>
<td>• Publication on hold for nationwide rollout</td>
<td>• Review process for disputed inspection reports scheduled for October with plans for stress testing.</td>
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<tr>
<td>Strategic relationship</td>
<td>• Strategic relationship management approach in place</td>
<td>• Assessment centre for inspectors in October for Relationship Manager roles</td>
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<tr>
<td>management</td>
<td>• Job role profile drafted</td>
<td>• Follow up of initial visits with pilot sites</td>
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<td></td>
<td>• Testing with 6 multiples</td>
<td></td>
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<tr>
<td>IT</td>
<td>• First test stage of Interim IT SharePoint solution completed</td>
<td>• Evaluation of Interim IT solution and on site data capture</td>
</tr>
<tr>
<td></td>
<td>• IT options for on-site evidence capture being tested</td>
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</table>
Council meeting 12 September 2013

Public business

Registered pharmacies: update on guidance and Rules

Purpose
To provide an update to Council on progress to develop supplementary guidance to the standards for registered pharmacies as well as our approach to consultation on the Rules.

Recommendations
The Council is asked to agree the revised scope of the three guidance documents to support the standards for registered pharmacies and the proposed approach to the consultation on Rules.

1. Introduction

1.1 The Pharmacy Order 2010 provides Council with a number of functions and powers in relation to registered pharmacies. These cover requirements in relation to registration of pharmacies, setting of standards, as well as a range of enforcement mechanisms.

1.2 We see the standards as sitting at the heart of this, describing the outcomes we require from registered pharmacies and placing a clear accountability on owners and superintendents for meeting the standards.

1.3 Although it is a year since the standards for registered pharmacies were approved a number of further steps are required:
   - Further guidance will be published on three key topics
   - The standards must be put into Rules
   - Following approval of the Rules, we will need to finalise our enforcement processes
2. Developing and consulting on guidance

2.1 In September 2012, Council proposed supplementary guidance on three key topics covering: preparation of (unlicensed) medicines at a registered pharmacy; guidance for pharmacies undertaking internet supplies; and guidance for pharmacies wishing to allow self-selection of P medicines.

2.2 The scope, draft content and timings for each of these has changed following further consideration of the relevant issues and following feedback from stakeholders.

2.3 It is our intention, following feedback from Council, finalise drafting, consult informally and publish the guidance documents.

2.4 An outline schedule for publication of guidance is set out in appendix 1 which also confirms our intention to publish guidance on the supply of P medicines at a later date to the other two pieces of proposed guidance.

3. Update on guidance for pharmacies preparing medicines

3.1 European\(^1\) and UK\(^2\) (commonly referred to as a Section 10 exemption) allows pharmacists to prepare medicines in a registered pharmacy without the need for an MHRA manufacturer’s license. When using the word ‘prepare’ in this context, it is intended to describe the process whereby medicines are made from ingredients, as opposed to simply diluting or dissolving a product. Products which are ‘prepared’ within a pharmacy do not have a relevant Marketing Authorisation and are unlicensed medicines.

3.2 Given the relative risk, and the complexity in the legal position, Council agreed that it would be appropriate to develop guidance for those wishing to prepare medicines under a ‘section 10 exemption’. We have, over the past year, had a number of discussions with staff at the MHRA about related issues and how to ensure our guidance is consistent with those of the MHRA.

3.3 In advance of the Council meeting in September 2012, the GPhC had identified an issue in relation to the legal framework for the supply of unlicensed extemporaneously prepared methadone (prepared under this section 10 exemption). Our conclusion at the time was that although it would be legal to prepare unlicensed methadone, it would not be legal to supply it, where an alternative licensed product was available. Our communications at the time emphasised the importance of placing patient care first and that where this was a potential issue there was no reason for pharmacies to interrupt supplies of medicines. We committed to further engagement with pharmacy organisations and other regulatory bodies on this issue.

\(^{1}\) Community Code relating to medicinal products for human use

\(^{2}\) Medicines Act 1968 and Human Medicines Regulations 2012
3.4 Following feedback and further consideration, we need to take account of further legal advice received on the complex legal issues involved. Our understanding of the legal test to be applied is now that extemporaneously prepared unlicensed methadone may be supplied lawfully if this is in accordance with a prescription for an individual patient. Our guidance will need to set this out and explain how we feel risks need to be mitigated for pharmacies carrying out preparation of medicines and their requirements under our standards for registered pharmacies. This change in interpretation will also be built into the new inspection model.

3.5 The GPhC has shared a draft copy of this guidance with MHRA for feedback on the relevant technical aspects and we intend to publish the guidance in draft form by the end of September.

4. Update on guidance for pharmacies supplying medicines over the internet.

4.1 We have also confirmed our intention to widen the scope of guidance for internet pharmacies to cover those pharmacies carrying out other forms of distance selling, such as mail order. There are a number of complex legal issues, including cross-border retail and EU legislation which we need to consider before finalising this guidance. We have already had discussions with MHRA given the overlaps in jurisdiction.

4.2 The speed at which technology is changing, coupled with our recognition that the issues raised are applicable to more than this one specific technological innovation has led us to conclude that further research and engagement is required. This work is scheduled to take place later this month and into October.

5. Guidance on self-selection of P Medicines

5.1 The initial decision to develop guidance on this topic came about in response to a perceived lack of clarity of some within pharmacy about what the move to outcome focussed standards might mean and in particular who would be accountable for decision making in this area.

5.2 For some time we have recognised that if the guidance was to focus on outcomes for patients and support professional decision making, it would need to cover the supply of all P medicines, not just those which may be on open display in future. As the legal requirement is for the sale and supply of all P medicines to be done under the supervision of a pharmacist, the guidance should reflect this and recognise that there are issues of equal significance in relation to quality of advice and decision making, regardless of the layout of the pharmacy.

5.3 We are therefore developing guidance on the supply of P medicines from registered pharmacies.

5.4 It is our current intention to publish a background paper later this month which will set out some of the issues we think need to be clarified and the likely content which will need to be covered in guidance.
5.5 Given Council’s policy position not to allow self selection before the introduction of Rules, it is not our plan to publish draft guidance until much closer to that date.

6. Drafting and approving Rules

Background and process

6.1 The Pharmacy Order 2010 (article 4(3)(b)) states that one of the Council’s principal functions is to ‘set and promote standards for the safe and effective practice of pharmacy at registered pharmacies’. The Council is also required to make rules in relation to these standards. Article 7(1) of the Pharmacy Order states that:

‘In the exercise of its functions under article 4(3)(b), the Council must make provision in rules about the standards that are to be met in connection with the carrying on of a retail pharmacy business at a registered pharmacy’.

6.2 These rules should allow the GPhC to use the powers of enforcement provided within the Pharmacy Order and to obtain information about registered pharmacies to enable it to carry out its regulatory responsibilities.

6.3 The rules are a form of secondary legislation – a statutory instrument. The process for making rules involves a complex drafting and quality assurance process, a sequence of Council discussions and decisions, and a public consultation period in order to obtain feedback from stakeholders. The draft rules are also scrutinised by government officials and solicitors, who act as the Privy Council’s advisers for this purpose.

6.4 Rules which are in a statutory instrument must be cleared by the Privy Council’s advisers before they can be made. Once the rules are made, they are then subject to parliamentary scrutiny before coming into force. By its nature, making rules is a thorough and lengthy process. We are liaising with the Privy Council’s advisers in order to make progress on the rules; nevertheless, the timetable may be disrupted if government priorities shift and advisers are diverted to other work.

Issues for consideration

6.5 Unusually, the Pharmacy Order requires that the standards for registered pharmacies are set out in the rules themselves. Where a regulator adopts a ‘rules-based’ approach which seeks to enable a binary judgement to be made, having standards placed in legislation would be both logical and easier to draft.

6.6 However, where the standards focus on outcomes, describing what needs to be achieved, rather than what activity, or how an activity must be carried out, then it becomes problematic to draft into legislation.

6.7 Although we would prefer for the standards to be fully enforceable without being inserted into legislation, the advice is that this would require an amendment to
the Pharmacy Order. We have concluded that we may be required to make some textual changes to the standards as part of the process of incorporating them into draft legislation.

6.8 Given that we will have to make some minor drafting changes to the standards to enable them to be incorporated into legislation, and that the Rules consultation document will necessarily include the standards, it is our recommendation that we should both take the opportunity to consider any specific drafting changes to be made to the standards and present those to Council in November as part of the draft Rules consultation.

6.9 It is not our intention to consult on the general approach to outcome focussed standards already agreed by Council, but we are currently reviewing the feedback from the consultant drafting the Rules as well as reviewing the standards to consider any additional drafting improvements we might need to make either that we have identified ourselves, or following feedback.

6.10 We would also intend to test the standards (and the new inspection model) against the themes and issues we have identified as relevant to us from the Francis Report.

6.11 Any drafting changes to the standards will be identified and considered by Council as part of the process of approval for consultation.

6.12 By providing a further opportunity for feedback on the standards, we propose both to use it as an opportunity to promote them further to owners of pharmacies and registrants, but we also recognise it will provide a further opportunity for the public, patient organisations, pharmacy organisations, registrants and others to provide feedback on individual issues of concern. This includes the issue of open display of P medicines which remains a concern for some within pharmacy.

6.13 Finally, further work is ongoing to develop our approach and operational processes required to enable publication of inspection reports. This work will continue alongside the consultation on Rules and in advance of our full powers of enforcement being in place. It is our intention to being the consultation on Rules to Council in November for approval.

7.  **Equality and diversity implications**

7.1 We are currently developing a draft equality impact analysis document for the registered pharmacy Rules consultation

8.  **Communications implications**

8.1 Rules consultations often simply seek feedback on the way in which previously consulted and agreed policies are translated into legislation. In this case we will require greater communications resources to manage the process given the possible changes to the content of the standards. It will be important that the consultation is clear on the areas and issues where we are seeking feedback,
which are likely to be the new enforcement powers and registration requirements, as well as specific changes to the standards we are proposing.

8.2 Specific plans for engagement and communications activity associated with the Rules consultation will be developed between now and November when Council will consider the draft consultation document.

8.3 We continue to work closely with key stakeholders in advance of publication of draft guidance. We have continued to keep those organisations who have expressed a specific interest in our guidance on the preparation of medicines within pharmacies informed. We will be focusing our engagement activities with those interest groups with a direct interest in the topics as well as patients and the public.

9. Resource implications

9.1 Work to develop the guidance documents will be met from existing budgets. We will consider whether we have sufficient resources in current budgets to manage the revised scope of the Rules consultation. Further details will be provided to Council in November.

10. Risk implications

10.1 We have taken steps to mitigate risks in the development of guidance by seeking legal advice where necessary, and involving others in the early development of the guidance. Likewise with the Rules, we have worked extensively with our own consultant who is an expert on legislative drafting and will seek to maximise the consultation period to seek input. Given the technical nature of Rules and the Privy Council and parliamentary approvals process there will continue to remain a risk of further delay.

Recommendations

The Council is asked to agree the revised scope of the three guidance documents to support the standards for registered pharmacies and the proposed approach to the consultation on Rules.

Hugh Simpson, Director of Policy and Communications

General Pharmaceutical Council

hugh.simpson@pharmacyregulation.org
tel 020 3365 3516

23 August 2013
Appendix 1

Schedule for publication of guidance

<table>
<thead>
<tr>
<th></th>
<th>Sept to November</th>
<th>December to January</th>
<th>February to March</th>
<th>March to June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance on preparation of medicines (section 10)</td>
<td>Feedback received on draft guidance</td>
<td>Guidance to be finalised</td>
<td>Feedback received on draft guidance</td>
<td>Guidance to be finalised</td>
</tr>
<tr>
<td>Guidance for distance selling pharmacies</td>
<td>Draft to be prepared and published</td>
<td>Feedback received on draft guidance</td>
<td>Guidance to be finalised</td>
<td></td>
</tr>
<tr>
<td>Guidance on the supply of Pharmacy medicines</td>
<td>Background paper to be published</td>
<td>Draft guidance to be considered by Council</td>
<td>Draft guidance to be published and feedback received</td>
<td>Guidance finalised</td>
</tr>
</tbody>
</table>

Inspection model launched
4 November 2013
Performance Monitoring

Purpose
To report to the Council on operational and financial performance.

Recommendations
The Council is asked to comment on and note the performance report at Appendix 1.

1. Introduction
1.1. This paper reports on operational and financial performance to the end of July 2013 at Appendix 1

2. Equality & diversity implications
2.1. The purpose of this report is to report on operational and financial performance. There are no direct equality and diversity implications.

3. Communications implications
3.1. The development and publication of this report is reflective of our commitment to openness and transparency concerning our performance. We have undertaken, and will continue to develop, specific communications on each of the areas of reported performance. This includes information on our website, wider communications through the media and direct through our own publications and communications materials. These activities are designed to reach all our key interest groups including patients and their representatives, pharmacy professionals and their employees, education providers and others.

4. Resource implications
4.1. Resource implications are addressed within the report.
5. **Risk implications**

5.1. Failure to maintain an accurate register, and/or carry out our other regulatory functions efficiently and effectively could have implications on patient safety, and have a significant impact on the reputation of the GPhC.

5.2. Failure to accurately forecast / budget for revenues and expenditure could lead to inappropriate or inconsistent fee policies which could have an adverse impact on the GPhC’s reputation.

**Recommendations**

The Council is asked to comment on and note the performance report at Appendix 1.

_Duncan Rudkin, Chief Executive & Registrar_
_duncan.rudkin@pharmacyregulation.org_
_tel 020 3365 3501_

_27 August 2013_
Appendix 1

Performance Monitoring Report

Reporting period: end of July 2013
## Contents

1. **Registration** ........................................................................................................... 5  
   1.1 The Register ........................................................................................................... 5  
   1.2 Applications processing ........................................................................................ 5  
   1.3 Pre-Registration ...................................................................................................... 7  
   1.4 Registration Assessment ........................................................................................ 7  

2. **Continuing Professional Development** ................................................................. 9  
   2.1 Overview ................................................................................................................ 9  
   2.2 Quality Assurance ................................................................................................. 10  

3. **Education** ............................................................................................................. 12  
   3.1 Introduction ........................................................................................................... 12  
   3.2 Summary of accreditation/recognition activity in 2012/2013 ................................. 12  
   3.3 Summary overview of accreditation and recognition activity 2012-2013 ............... 16  
   3.4 Planned education quality assurance activity in the academic year 2013-2014 ... 17  
   3.5 All accredited and recognised courses at 1 September 2013 ................................ 18  

4. **Fitness to Practise** ................................................................................................. 23  
   4.1 Introduction ........................................................................................................... 23  
   4.2 Total case load ..................................................................................................... 23  
   4.3 Age profile of overall case load ............................................................................. 24  
   4.4 Target to close 95% of all FtP cases within 12 months ......................................... 24  
   4.5 Cases over 15 months .......................................................................................... 24  
   4.6 Fitness to Practise Activity August 2012 to July 2013 ......................................... 25  
   4.7 Statutory appeals .................................................................................................. 26  

5. **Organisational Feedback** ....................................................................................... 27  
   5.1 Introduction ........................................................................................................... 27  
   5.2 Total number of complaints ................................................................................... 27  
   5.3 Breakdown by theme/category .............................................................................. 28  
   5.4 Positive feedback .................................................................................................. 29  

6. **Financial Performance** ........................................................................................ 30  
   6.1 Comparative data ................................................................................................... 30  
   6.2 Year to date .......................................................................................................... 30  
   6.3 Balance sheet .................................................................................................... 30  

Appendix 2 - Board of Assessors Report ......................................................................... 34
1. Registration

This section provides an overview of key registration activity undertaken by the Customer Services Team.

1.1 The Register

<table>
<thead>
<tr>
<th></th>
<th>Jun-13</th>
<th>Additions</th>
<th>Removals</th>
<th>Other *</th>
<th>Jul-13</th>
<th>Budget ed numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Voluntary Removal</td>
<td>Non Renewal</td>
<td>FTP Comm</td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td>47,404</td>
<td>55</td>
<td>47</td>
<td>25</td>
<td>0</td>
<td>47,394</td>
</tr>
<tr>
<td>Pharmacy Technicians</td>
<td>21,899</td>
<td>110</td>
<td>32</td>
<td>15</td>
<td>0</td>
<td>21,967</td>
</tr>
<tr>
<td>Premises</td>
<td>14,250</td>
<td>48</td>
<td>24</td>
<td>0</td>
<td>-4</td>
<td>14,270</td>
</tr>
<tr>
<td>Pre registration trainees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,728</td>
<td>3,100</td>
</tr>
</tbody>
</table>

* Restoration and other register classification changes

1.1.1 The pre-registration actual includes new entrants to the pre-registration scheme for 2013 – 2014, those currently on the scheme who have not yet registered, having been successful in their registration assessment and two cohorts of Bradford sandwich students, those who are completing their 6 months placement between January and July and those entering the July to Jan placement. Therefore at this time of year there is always an overlap of records.

1.2 Applications processing

1.2.1 Between January 2013 to end of July 2013 applications for registration were tracked to establish the processing turnover rate.

- Applications were tracked two ways
  - Application receipt to approval
  - Application receipt to registration
<table>
<thead>
<tr>
<th></th>
<th>Days</th>
<th></th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy Technician</strong></td>
<td></td>
<td><strong>Pharmacist</strong></td>
<td></td>
</tr>
<tr>
<td><strong>New Applications 01/01/2013 – 31/07/2013</strong></td>
<td></td>
<td><strong>New Applications 01/01/2013 – 31/07/2013</strong></td>
<td></td>
</tr>
<tr>
<td>Application receipt to approval</td>
<td>Minimum 1</td>
<td>Application receipt to approval</td>
<td>Minimum 1</td>
</tr>
<tr>
<td></td>
<td>Mean¹ 5</td>
<td></td>
<td>Mean 10</td>
</tr>
<tr>
<td></td>
<td>Median² 1</td>
<td></td>
<td>Median 6</td>
</tr>
<tr>
<td></td>
<td>Maximum 84</td>
<td></td>
<td>Maximum 91</td>
</tr>
<tr>
<td>Application receipt to approval</td>
<td>Minimum 1</td>
<td>Application receipt to approval</td>
<td>Minimum 1</td>
</tr>
<tr>
<td></td>
<td>Mean 12</td>
<td></td>
<td>Mean 21</td>
</tr>
<tr>
<td></td>
<td>Median 11</td>
<td></td>
<td>Median 20</td>
</tr>
<tr>
<td></td>
<td>Maximum 118</td>
<td></td>
<td>Maximum 128</td>
</tr>
</tbody>
</table>

1.2.2 The outliers tend to be those applicants with FTP matters that need further investigation and consideration at the point of registration, applications where the payment fails and where there is more information or clarification required to validate the application.

1.2.3 Also applications from those previously on the register where a portfolio of evidence is now required to be independently assessed by external evaluators.

1.2.4 We have two entry points onto the register, the first and the fifteenth of the month.

¹ The mean figure is the average which includes significant outliers.
² The median figure indicates the 50th percentile. In other words, 50% of the data falls between the minimum and median figure.
1.3 Pre-Registration

<table>
<thead>
<tr>
<th>Measure</th>
<th>London 1</th>
<th>London 2</th>
<th>London 3</th>
<th>Bath</th>
<th>Birmingham</th>
<th>Manchester</th>
<th>Bradford</th>
<th>Sunderland</th>
<th>Edinburgh</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total trainees eligible to sit</td>
<td>584</td>
<td>432</td>
<td>133</td>
<td>212</td>
<td>429</td>
<td>371</td>
<td>254</td>
<td>134</td>
<td>175</td>
<td>2,724</td>
</tr>
<tr>
<td>Total trainees applied to sit</td>
<td>550</td>
<td>405</td>
<td>125</td>
<td>204</td>
<td>426</td>
<td>354</td>
<td>253</td>
<td>132</td>
<td>172</td>
<td>2,621</td>
</tr>
<tr>
<td>No. of withdrawals</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>No. &quot;no shows&quot; on the day</td>
<td>10</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>Total no. of trainees sitting</td>
<td>537</td>
<td>398</td>
<td>122</td>
<td>204</td>
<td>420</td>
<td>348</td>
<td>247</td>
<td>129</td>
<td>172</td>
<td>2,577</td>
</tr>
<tr>
<td>No. of adjustments (inc in figs)</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>17</td>
<td>4</td>
<td>14</td>
<td>0</td>
<td>1</td>
<td>74</td>
</tr>
<tr>
<td>No. of requests to nullify</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

* Between mid November 2012 and mid July 2013 (8 months) we processed and either approved or gave a 1 year provisional approval to ~ 1,150 training sites for the provision of pre-registration training.

1.4 Registration Assessment

1.4.1 The registration assessments were sat on 28 June 2013, and were held at 9 centres spread across the country.

1.4.2 A breakdown of the main statistics for the day is shown in the table below. These statistics are prior to the Board of Assessors results awarding meeting.
1.4.3 From the nullification requests taken to the Board of Assessors meeting:
   - Granted -6
   - Rejected - 1
   - Pending (further evidence required) - 1

1.4.4 A total of 1999 (77.8%) successfully passed the assessment. 1,216 and 387 new pharmacists were added to the register on 1st and 15th August respectively. This pass rate is lower than for the registration assessment last year. Further analysis of this year’s registration assessment is presented to Council at Appendix 2.

1.4.5 Arrangements are now being made for the Autumn registration assessments, to be held on 27th September 2013. There are 865 candidates eligible to sit the assessment, which will be held in 3 centres, in London, Manchester and Edinburgh.

1.4.6 Centre allocation letters were sent to all eligible candidates on 8 August, with a closing date for applications of 16 August.

1.4.7 As with the registration assessment last year, we surveyed candidates immediately after the assessment. This was in the form of an online survey and concentrates on obtaining feedback on our administrative arrangements.

1.4.8 A total of 843 responses were received (34%). Scores for each question about the assessment day ranged from 76% - 94%, indicating a high level of satisfaction with the arrangements.

1.4.9 In answer to the question “Overall, leaving aside the exam content itself, how would you describe your registration experience?” the satisfaction rating was 75.8%.

1.4.10 There were many comments left by candidates as additional feedback which we are assessing for any additional administrative improvements. However, despite the phrasing of the question, the vast majority related to the content of the assessment itself rather than the assessment day arrangements.

1.4.11 The Board of Assessors report on the June sitting of the registration assessment is presented to Council at Appendix 2.
## 2. Continuing Professional Development

The CPD section provides an overview of the CPD activity undertaken by the Customer Services Team.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Records Requested</td>
<td>2,494</td>
<td>2,551</td>
<td>2,539</td>
<td>1,601</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Records Reviewed</td>
<td>1,303</td>
<td>1,596</td>
<td>2,462</td>
<td>2,376</td>
<td>2,353</td>
<td>2,190</td>
</tr>
<tr>
<td>Reminders Sent</td>
<td>178</td>
<td>231</td>
<td>402</td>
<td>223</td>
<td>149</td>
<td>118</td>
</tr>
<tr>
<td>CPD Online Submissions</td>
<td>1,748</td>
<td>2,288</td>
<td>2,140</td>
<td>1,726</td>
<td>2,271</td>
<td>680</td>
</tr>
<tr>
<td>Paper Submissions</td>
<td>72</td>
<td>115</td>
<td>109</td>
<td>71</td>
<td>117</td>
<td>55</td>
</tr>
<tr>
<td>Dual Submissions</td>
<td>6</td>
<td>9</td>
<td>3</td>
<td>19</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Feedback Sent</td>
<td>1,376</td>
<td>1,461</td>
<td>2,096</td>
<td>2,390</td>
<td>2,782</td>
<td>2,275</td>
</tr>
</tbody>
</table>

### 2.1 Overview

#### 2.1.1 The last call cycle ran from November 2012 to May 2013. During this cycle 14,188 records were called with another 44 record recalls. We are continuing to process non-compliance cases under the CPD Rules.

#### 2.1.2 To date 127 Notices of Intention to remove have been issued to registrants who have failed to submit their CPD record. We have received 8 written representations from registrants outlining why their entry in the register should not be removed. This has resulted in remedial measures being set in 5 cases, including 1 referral to FTP for health concerns, 1 request for further evidence, the issuing of 1 notice of removal and 1 case which is still pending.

#### 2.1.3 A further 15 Notices of removal have been issued to registrants who did not respond to the Notice of Intention to remove. There has been 1 removal from the register for non-submission of CPD. These figures are likely to increase as more cases are processed. To date there have not been any requests for a hearing and there have been no appeals.

#### 2.1.4 30 July 2013 marks 4 years since call and review began. During this time 39,335 CPD records were called for review and 39,275 records were reviewed.

#### 2.1.5 The most popular means of making a submission is via the CPD Online system with 95% of registrants in 2013 submitting their CPD record online compared to 87% in the first year of call and review.
2.1.6 Overall the quality of submitted records has improved each year. In 2013 96.08% achieved an ‘excellent’ rating, indicating that at least 75% of the total assessable criteria were met, compared to the first year of call and review where 82.2% of registrants met this rating. The quality of CPD records in terms of their rating against the CPD review criteria: 75%-100% of the CPD review criteria. The ratings are as follows 75-100% (Excellent), 50-74% (Good), 25-49% (Look at again), 0-24% (Urgent Attention).

2.1.7 The average number of days between request of a CPD record and the submission being received was 41. The average number of days between submission of a record and its review was 14 and the average number of days between review of records and the supply of feedback reports to registrants was 7.

2.2 Quality Assurance

2.2.1 Quality checks are undertaken each month across all processing teams and the customer contact centre (CCC). The aim is to ensure that all processes and all individual staff are covered by these checks. However, as not all processes are performed each month, and not all staff cover all tasks, a matrix management approach is taken to ensure that, over the year, we have evidenced all processes covered by all staff that are involved in them, and that sufficient checks are performed on all staff.

2.2.2 Within the CCC, 5 calls and 5 e-mails are checked each month for each staff member. The KPI for the department overall and for each staff member is to achieve an average score of at least 80% across all quality checks, and for at least 80% of all checks to reach the pass mark.

2.2.3 For the applications teams, a minimum of 5 process checks per team member per month is required from the team managers from the tasks that they are undertaking during the period, with the monthly results plotted onto a grid to ensure that all tasks are checked for all staff over the year, and to identify where the gaps are for future QA checks.

2.2.4 In addition, specific checks are carried out on higher risk activities to ensure accuracy, especially around integrity of the Register – for example:

- Cases being handled by the hearings team are tracked and actioned immediately should removal or suspension be required. All cases are quality checked.
- All applications where new registrants are being added to the Register are quality checked.
- All EEA applications are subject to QA checks.
- All applications from previous registrants aiming to return to the Register are reviewed.
- All cases requiring a good character assessment or health assessment are reviewed.
• All potential cases of removal from the register are reviewed including non-payment of renewal fees and CPD non-compliance.

2.2.5 A summary of results is as follows (to 30/6/13):

**Contact Centre**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone calls</td>
<td></td>
</tr>
<tr>
<td>Number of QA checks</td>
<td>231</td>
</tr>
<tr>
<td>% passed</td>
<td>98.7%</td>
</tr>
<tr>
<td>Average score</td>
<td>96.1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Emails</td>
<td></td>
</tr>
<tr>
<td>Number of QA checks</td>
<td>228</td>
</tr>
<tr>
<td>% passed</td>
<td>95.2%</td>
</tr>
<tr>
<td>Average score</td>
<td>94.3</td>
</tr>
</tbody>
</table>

**Applications Teams**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of checks</td>
<td>1,100</td>
</tr>
<tr>
<td>% passed</td>
<td>99.3%</td>
</tr>
</tbody>
</table>
3. Education

This section presents the education quality assurance activity in the academic year 2012-2013.

3.1 Introduction

3.1.1 The GPhC accredits the following courses for pharmacists:

- 4-year MPharm degrees. The full reaccreditation period is six years, with an interim visit after three years.
- 5-year MPharm degrees (with integrated pre-registration training). The full reaccreditation period is six years, with an interim visit after three years.
- 4-year MPharm degrees delivered in part overseas (2 years overseas and 2 years in GB, hence ‘2+2’). The full reaccreditation period is six years, with an interim visit after three years.
- Overseas Pharmacists’ Assessment Programmes (OSPAPs) – 1-year conversion courses for non-EEA pharmacists wanting to register in GB. The full reaccreditation period is three years.
- Post-registration independent prescribing courses for pharmacists. The full reaccreditation period is three years.

3.1.2 Course providers are accredited directly. After a period of time, new course providers are reaccredited.

3.1.3 The GPhC recognises pharmacy technician qualifications. Recognition varies from accreditation in that it validates national qualifications bodies who quality assure multiple providers through their own mechanisms rather than accrediting providers directly.

3.1.4 Although the GPhC does not register pharmacy support staff it does set standards for their education and training. The GPhC accredits courses for Dispensing assistants and Medicines counter assistants.

3.2 Summary of accreditation/recognition activity in 2012/2013

<table>
<thead>
<tr>
<th>Course provider</th>
<th>Course</th>
<th>Accreditation type</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Lincoln</td>
<td>MPharm degree</td>
<td>Step 2 accreditation</td>
<td>Approved to progress to step 3 – no conditions, but there will be an interim visit to monitor progress in advance of step 3 because some processes were still being developed at the time of the visit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1st cohort of students to be admitted</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Accreditation type</td>
<td>Outcome</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>University of Birmingham</td>
<td>MPharm degree (4-yr course)</td>
<td>Step 3 accreditation</td>
<td>in October 2014, subject to a successful step 3 visit.</td>
</tr>
<tr>
<td>University of Birmingham</td>
<td>MPharm degree (5-yr course with integrated pre-registration training)</td>
<td>Step 3 accreditation</td>
<td>Approved to progress to step 4 – 1 condition.</td>
</tr>
<tr>
<td>Durham University</td>
<td>MPharm degree</td>
<td>Step 3 accreditation</td>
<td>Progression to step 4 was not permitted.</td>
</tr>
<tr>
<td>University of Ulster</td>
<td>MPharm degree</td>
<td>Step 7 accreditation</td>
<td>Approved for full accreditation for 2 years. This is the final accreditation using the previous set of standards. Ulster will be redesigning its degree and representing it in two years’ time after it has been mapped to the new standards. The first cohort of students graduated in 2013.</td>
</tr>
<tr>
<td>Aston University</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – 1 condition. A visit will take place in three years to review the delivery of the new curriculum. The team felt that integration was present in parts but not fully embedded in the course.</td>
</tr>
<tr>
<td>Kingston University</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – 2 conditions.</td>
</tr>
<tr>
<td>Medway School of Pharmacy</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – no conditions.</td>
</tr>
<tr>
<td>The Robert</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – no conditions.</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Accreditation type</td>
<td>Outcome</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------</td>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Gordon University</td>
<td></td>
<td></td>
<td>conditions.</td>
</tr>
<tr>
<td>University College London</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – no conditions.</td>
</tr>
<tr>
<td>University of Bath</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for 3 years – 1 condition. Bath was granted 3 years because its course was insufficiently integrated, needs more clinical work and inter-professional engagement and its assessment strategy needs revision.</td>
</tr>
<tr>
<td>University of Brighton</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for 2 years – 2 conditions. Brighton was granted 2 years because its assessment strategy needs revision, staffing is insufficient and student feedback is weak at course and university levels.</td>
</tr>
<tr>
<td>University of Hertfordshire</td>
<td>MPharm degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – no conditions</td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>MPharm degree (5-yr course with integrated pre-registration training)</td>
<td>Step 1 Accreditation</td>
<td>Approved to progress to Step 2 – 1 condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>The first cohort of student will graduate in 2018.</strong></td>
</tr>
<tr>
<td>Kingston University</td>
<td>Pharmacy Foundation degree</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 6 years – no conditions</td>
</tr>
<tr>
<td>Queen's University Belfast</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – 1 condition</td>
</tr>
<tr>
<td>York University</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – no conditions</td>
</tr>
<tr>
<td>The Robert Gordon University</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – 1 condition</td>
</tr>
<tr>
<td>The Robert Gordon University</td>
<td>Independent Prescribing conversion</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – no conditions</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Accreditation type</td>
<td>Outcome</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>University of Cumbria</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – 1 condition</td>
</tr>
<tr>
<td>St George’s University of London (in partnership with Kingston University)</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Event was halted due to unsatisfactory answers to questions during event and the provider’s out of date and poor quality documentation. To be rescheduled pending course provider’s decision as to whether it plans continue the programme once the current accredited expires.</td>
</tr>
<tr>
<td>University of Bradford</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – 1 condition</td>
</tr>
<tr>
<td>Keele University</td>
<td>Independent Prescribing</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – 1 condition</td>
</tr>
<tr>
<td>Scientia Skills</td>
<td>Medicines Counter Assistant course</td>
<td>Reaccreditation</td>
<td>Approved for a full period of 3 years – 1 condition</td>
</tr>
<tr>
<td>MediaPharm</td>
<td>Medicines Counter Assistant course</td>
<td>Reaccreditation</td>
<td>Postponed – the event scheduled for June 2013 had to be postponed. At the pre-visit meeting it was evident that the provider was not prepared for reaccreditation. Event rescheduled to take place in September 2013.</td>
</tr>
<tr>
<td>National Pharmacy Association (NPA)</td>
<td>Dispensing Assistant course – variation of NPA accredited course for assistants who only work with pharmacy stock</td>
<td>Accreditation</td>
<td>Accreditation not granted. This event was undertaken as a paper-based review. This version of the course was deemed not yet ready for accreditation and the provider has to revise their programme materials and resubmit them for further review.</td>
</tr>
<tr>
<td>The Robert Gordon University</td>
<td>OSPAP</td>
<td>Course closure</td>
<td>Due to small numbers of applicants, RGU has decided to close its OSPAP. Students may not enter from October 2013.</td>
</tr>
</tbody>
</table>
3.3 Summary overview of accreditation and recognition activity 2012-2013

*MPharm degree*

3.3.1 The universities of Birmingham and Durham will admit their first cohort of 4-year MPharm degree students in October 2013.

3.3.2 The University of Birmingham will not be proceeding with its 5-year integrated MPharm degree with integrated pre-registration training.

3.3.3 The University of Lincoln is planning to admit its first cohort of MPharm degree students in October 2014.

3.3.4 The Robert Gordon University has closed its OSPAP course – no students will be admitted from October 2013.

3.3.5 The University of Ulster graduated its first MPharm degree students in 2013.

3.3.6 Each MPharm degree provider was offered a debrief meeting this year, which will become a permanent feature of accreditation in the future.

3.3.7 Accreditation teams have observed that the MPharm degrees reviewed this year have displayed varying levels of integration, from minimal through to full. As integration is required in our standards, courses that were not well integrated were given a shorter than normal period of reaccreditation, in which they will be redesigning their courses in preparation for re-representation to the GPhC.

3.3.8 The first accreditation events for 5-year integrated MPharm degrees took place this year. The accreditation of 5-year MPharm degrees was permitted only with agreement that the courses would not draw on public funding from the pre-registration training grant, or impact on current preregistration training provision.

3.3.9 For the first time, it was found necessary to impose a maximum intake of students for one provider, because that provider had increased student numbers without prior consultation on several occasions. The basis of the decision was that the accreditation team agreed that the provider did not have sufficient resources to deliver its MPharm degree to cohorts larger than the current cohort.

*Independent Prescribing*

3.3.10 A number of the conditions set this year for independent prescribing programmes concerned assessment marking processes in relation to safe practice. This is not to suggest that assessment practices were unsafe, more that they were unclear.
### 3.4 Planned education quality assurance activity in the academic year 2013-2014

<table>
<thead>
<tr>
<th>Course provider</th>
<th>Course</th>
<th>Type (initial accreditation/reaccreditation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Sunderland</td>
<td>MPharm</td>
<td>interim visit*</td>
</tr>
<tr>
<td>University of Strathclyde</td>
<td>MPharm</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Wolverhampton</td>
<td>MPharm</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>King’s College London</td>
<td>MPharm</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Reading</td>
<td>MPharm</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Huddersfield</td>
<td>MPharm</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Birmingham</td>
<td>MPharm</td>
<td>Step 4 accreditation</td>
</tr>
<tr>
<td>Durham University</td>
<td>MPharm</td>
<td>Step 4 accreditation</td>
</tr>
<tr>
<td>University of Lincoln</td>
<td>MPharm</td>
<td>Step 3 accreditation</td>
</tr>
<tr>
<td>University of Strathclyde in partnership with International Medical University (IMU), Malaysia</td>
<td>MPharm 2+2</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Reading in partnership with University of Reading Malaysia Campus, Malaysia</td>
<td>MPharm 2+2</td>
<td>Step 1 accreditation</td>
</tr>
<tr>
<td>Kingston University London</td>
<td>OSPAP</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Lincoln</td>
<td>Independent prescribing</td>
<td>accreditation</td>
</tr>
<tr>
<td>University of Sunderland</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Leeds</td>
<td>Independent prescribing (+ conversion)</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>King’s College London</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Portsmouth</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>City University London</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Anglia Ruskin University</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Reading</td>
<td>Independent prescribing (+ conversion)</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Bath</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Brighton</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>University of Strathclyde</td>
<td>Independent prescribing (+ conversion)</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>London South Bank University</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>De Montfort University</td>
<td>Independent prescribing (+ conversion)</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Type (initial accreditation/reaccreditation)</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>University of South Wales (formerly University of Glamorgan)</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Cardiff University</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Medway School of Pharmacy</td>
<td>Independent prescribing</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Buttercups Training</td>
<td>Medicines Counter Assistant</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>National Pharmacy Association (NPA)</td>
<td>Medicines Counter Assistant</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Buttercups Training</td>
<td>Dispensing Assistant</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>National Pharmacy Association (NPA)</td>
<td>Dispensing Assistant</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Boots</td>
<td>Dispensing Assistant</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Communications International Group (CIG) Healthcare Partnership</td>
<td>Dispensing Assistant</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>Buttercups Training</td>
<td>Pharmacy Technician knowledge-based qualification</td>
<td>reaccreditation</td>
</tr>
<tr>
<td>National Pharmacy Association (NPA)</td>
<td>Pharmacy Technician knowledge-based qualification</td>
<td>reaccreditation</td>
</tr>
</tbody>
</table>

*Interim visits*

The accreditation methodology includes an interim visit to take place three years after reaccreditation. The purpose of this visit is to review the nature, content and quality of the MPharm degree, which will be achieved by observing practice activities. In addition, outstanding issues will be followed up during the visit, mainly issues raised in the GPhC’s main report. The first formal interim visit is due in 2013/14. A series of pilot visits will be carried out before then and will involve a small number of schools of pharmacy who have volunteered to take part in the pilot phase.

### 3.5 All accredited and recognised courses at 1 September 2013

<table>
<thead>
<tr>
<th>Course provider</th>
<th>Course</th>
<th>Next Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aston University</td>
<td>MPharm degree</td>
<td>2018/19</td>
</tr>
<tr>
<td>University of Bath</td>
<td>MPharm degree</td>
<td>2015/16</td>
</tr>
<tr>
<td>University of Birmingham*</td>
<td>MPharm degree (1st intake 2013)</td>
<td>Step 4 2013/14</td>
</tr>
<tr>
<td>University of Bradford</td>
<td>MPharm degree</td>
<td>2017/18</td>
</tr>
<tr>
<td>University of Brighton</td>
<td>MPharm degree</td>
<td>2014/15</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Next Review date</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Cardiff University</td>
<td>MPharm degree</td>
<td>2014/15</td>
</tr>
<tr>
<td>University College London</td>
<td>MPharm degree</td>
<td>2018/19</td>
</tr>
<tr>
<td>University of Central Lancashire</td>
<td>MPharm degree</td>
<td>2015/16</td>
</tr>
<tr>
<td>De Montfort University</td>
<td>MPharm degree</td>
<td>2017/18</td>
</tr>
<tr>
<td>Durham University*</td>
<td>MPharm degree (1st intake 2013)</td>
<td>Step 4 2013/14</td>
</tr>
<tr>
<td>University of East Anglia</td>
<td>MPharm degree</td>
<td>2017/18</td>
</tr>
<tr>
<td>University of Hertfordshire</td>
<td>MPharm degree</td>
<td>2018/19</td>
</tr>
<tr>
<td>University of Huddersfield</td>
<td>MPharm degree</td>
<td>2013/14</td>
</tr>
<tr>
<td>Keele University</td>
<td>MPharm degree</td>
<td>2014/15</td>
</tr>
<tr>
<td>King's College London</td>
<td>MPharm degree</td>
<td>2013/14</td>
</tr>
<tr>
<td>Kingston University London</td>
<td>MPharm degree</td>
<td>2018/19</td>
</tr>
<tr>
<td>University of Lincoln*</td>
<td>MPharm degree (1st planned intake 2014)</td>
<td>Step 3 2013/14</td>
</tr>
<tr>
<td>Liverpool John Moores University</td>
<td>MPharm degree</td>
<td>2014/15</td>
</tr>
<tr>
<td>Medway School of Pharmacy (universities of Greenwich and Kent)</td>
<td>MPharm degree</td>
<td>2018/19</td>
</tr>
<tr>
<td>University of Manchester</td>
<td>MPharm degree</td>
<td>2014/15</td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>MPharm degree</td>
<td>2017/18</td>
</tr>
<tr>
<td>University of Portsmouth</td>
<td>MPharm degree</td>
<td>2017/18</td>
</tr>
<tr>
<td>Queen's University, Belfast</td>
<td>MPharm degree</td>
<td>2017/18</td>
</tr>
<tr>
<td>The Robert Gordon University</td>
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</tr>
<tr>
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<td>2013/14</td>
</tr>
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<td>MPharm degree</td>
<td>2013/14</td>
</tr>
<tr>
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<td>MPharm degree</td>
<td>2016/17</td>
</tr>
<tr>
<td>University of Ulster</td>
<td>MPharm degree</td>
<td>2014/15</td>
</tr>
<tr>
<td>University of Wolverhampton</td>
<td>MPharm degree</td>
<td>2013/14</td>
</tr>
</tbody>
</table>

*working towards full accreditation*
<table>
<thead>
<tr>
<th>Course provider</th>
<th>Course</th>
<th>Next Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston University London</td>
<td>Pharmacy Foundation Degree (Yr 1 taught over part-time two years, with additional study support; 5 years in total)</td>
<td>2018/19</td>
</tr>
<tr>
<td>Cardiff University in collaboration with Taylor’s University</td>
<td>MPharm 2+2</td>
<td>2014/15</td>
</tr>
<tr>
<td>Cardiff University in collaboration with Taylor’s University</td>
<td>MPharm 2+2</td>
<td>2017/18</td>
</tr>
<tr>
<td>University of Strathclyde</td>
<td>MPharm 2+2</td>
<td>2013/14</td>
</tr>
<tr>
<td>University of Sunderland in collaboration with SEGi University</td>
<td>MPharm 2+2</td>
<td>2015/16</td>
</tr>
<tr>
<td>Aston University</td>
<td>OSPAP</td>
<td>2014/15</td>
</tr>
<tr>
<td>University of Brighton</td>
<td>OSPAP</td>
<td>2014/15</td>
</tr>
<tr>
<td>University of Hertfordshire</td>
<td>OSPAP</td>
<td>2014/15</td>
</tr>
<tr>
<td>Kingston University London</td>
<td>OSPAP</td>
<td>2013/14</td>
</tr>
<tr>
<td>University of Sunderland</td>
<td>OSPAP</td>
<td>2014/15</td>
</tr>
<tr>
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<td>Apr 2014</td>
</tr>
<tr>
<td>University of Bangor</td>
<td>Independent prescribing</td>
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</tr>
<tr>
<td>University of Bath</td>
<td>Independent prescribing</td>
<td>Apr 2014</td>
</tr>
<tr>
<td>University of Bolton</td>
<td>Independent prescribing + conversion course for supplementary prescribers</td>
<td>Jan 2015</td>
</tr>
<tr>
<td>University of Bradford</td>
<td>Independent prescribing</td>
<td>Aug 2016</td>
</tr>
<tr>
<td>University of Brighton</td>
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</tr>
<tr>
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<td>Oct 2014</td>
</tr>
<tr>
<td>University of Central Lancashire</td>
<td>Independent prescribing</td>
<td>Dec 2014</td>
</tr>
<tr>
<td>University of Chester</td>
<td>Independent prescribing</td>
<td>Sep 2015</td>
</tr>
<tr>
<td>City University</td>
<td>Independent prescribing</td>
<td>Mar 2014</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Next Review date</td>
</tr>
<tr>
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</tr>
<tr>
<td>University of Cumbria</td>
<td>Independent prescribing</td>
<td>Sep 2016</td>
</tr>
<tr>
<td>De Montfort University</td>
<td>Independent prescribing + conversion course for supplementary prescribers</td>
<td>Jul 2014</td>
</tr>
<tr>
<td>University of Derby</td>
<td>Independent prescribing</td>
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</tr>
<tr>
<td>Edgehill University</td>
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<tr>
<td>Glyndwr University</td>
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</tr>
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</tr>
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<td>University of Hull</td>
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<td>Keele University</td>
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</tr>
<tr>
<td>University of Leeds</td>
<td>Independent prescribing + conversion course for supplementary prescribers</td>
<td>Jan 2014</td>
</tr>
<tr>
<td>London South Bank University</td>
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<td>Jul 2014</td>
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<tr>
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<td>University of Nottingham</td>
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<td>Dec 2014</td>
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<td>University of Portsmouth</td>
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<tr>
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<td>Independent prescribing + conversion course for supplementary prescribers</td>
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<tr>
<td>Robert Gordon University</td>
<td>Independent prescribing + conversion course for supplementary prescribers</td>
<td>Aug 2016</td>
</tr>
<tr>
<td>University of Salford</td>
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<td>Aug 2014</td>
</tr>
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<td>University of South Wales (Formerly University of Glamorgan)</td>
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<td>Aug 2014</td>
</tr>
<tr>
<td>University of Strathclyde</td>
<td>Independent prescribing + conversion course for supplementary prescribers</td>
<td>May 2014</td>
</tr>
<tr>
<td>University Campus Suffolk</td>
<td>Independent prescribing</td>
<td>Oct 2015</td>
</tr>
<tr>
<td>Course provider</td>
<td>Course</td>
<td>Next Review date</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>University of Sunderland</td>
<td>Independent prescribing</td>
<td>Jan 2014</td>
</tr>
<tr>
<td>Swansea University</td>
<td>Independent prescribing</td>
<td>Feb 2015</td>
</tr>
<tr>
<td>University of Wolverhampton</td>
<td>Independent prescribing</td>
<td>Sep 2015</td>
</tr>
<tr>
<td>University of York</td>
<td>Independent prescribing</td>
<td>May 2016</td>
</tr>
<tr>
<td>Buttercups Training</td>
<td>accredited pharmacy technician knowledge-base course</td>
<td>Mar 2014</td>
</tr>
<tr>
<td>National Pharmacy Association (NPA)</td>
<td>accredited pharmacy technician knowledge-base course</td>
<td>June 2014</td>
</tr>
<tr>
<td>Scottish Qualifications Authority (SQA)</td>
<td>accredited pharmacy technician knowledge-base course</td>
<td>Oct 2014</td>
</tr>
<tr>
<td>City and Guilds</td>
<td>recognition of pharmacy technician knowledge-based and competency based qualifications</td>
<td>ongoing*</td>
</tr>
<tr>
<td>EdExcel</td>
<td>recognition of pharmacy technician knowledge-based and competency based qualifications</td>
<td>ongoing*</td>
</tr>
<tr>
<td>Scottish Qualifications Authority (SQA)</td>
<td>recognition of pharmacy technician competency based qualification</td>
<td>ongoing*</td>
</tr>
</tbody>
</table>

*recognised on an ongoing basis, until such time as the national occupational standards are revised.

<table>
<thead>
<tr>
<th>Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent prescribing courses</td>
<td>36</td>
</tr>
<tr>
<td>MPharm degrees</td>
<td>29</td>
</tr>
<tr>
<td>Supplementary to independent prescriber conversion courses</td>
<td>6</td>
</tr>
<tr>
<td>OSPAP courses</td>
<td>5</td>
</tr>
<tr>
<td>MPharm 2+2 degrees</td>
<td>4</td>
</tr>
<tr>
<td>Knowledge-based pharmacy technician qualifications</td>
<td>3</td>
</tr>
<tr>
<td>Knowledge-based and competence-based pharmacy technician qualifications</td>
<td>3 + 3</td>
</tr>
<tr>
<td>Pharmacy Foundation degrees</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>90</td>
</tr>
</tbody>
</table>
4. Fitness to Practise

4.1 Introduction

4.1.1 The focus of the commentary for this reporting period relates to Fitness to Practise performance in June to July 2013. Also included for this reporting period is a summary of the data set used by the Professional Standards Authority (PSA) to monitor the timeliness of the GPhC’s fitness to practice activity. This covers performance for the year, August 2012 to July 2013.

4.2 Total case load

4.2.1 Table 1 below sets out the overall case load from June 2013 to July 2013 and for the cases closed, a breakdown of the stage of the process they were closed.

<table>
<thead>
<tr>
<th></th>
<th>Jun 13</th>
<th>New cases</th>
<th>Cases closed</th>
<th>Jul 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall case load</td>
<td>468</td>
<td>68</td>
<td>66</td>
<td>470</td>
</tr>
<tr>
<td>Stage closed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 4 closed by Fitness to Practise Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 14 closed by Investigating Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 12 closed Outside Our Jurisdiction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 8 closed under threshold criteria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 28 closed with advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2.2 In summary:

- Our overall caseload has increased from 468 at the end of June to 470 at the end of July.
- 66 cases were closed in July against a monthly average of 68 cases closed.
- 4 cases were closed by FtP Committee in July; this resulted in 1 removal from the register, 1 registrant was suspended and 2 registrants were given conditions.
- Of the 14 cases closed at Investigating Committee in July, 5 resulted in a warning letter being issued to the registrant and 9 resulted in a letter of advice being issued to the registrant.
4.3 **Age profile of overall case load**

4.3.1 Table 2 below sets out the age profile of the overall case load at the end of April 2013 (last Council report) and at the end of July 2013.

<table>
<thead>
<tr>
<th>Age profile of overall case load</th>
<th>Apr-13</th>
<th>Jul-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 6 months old</td>
<td>42.6%</td>
<td>54.89%</td>
</tr>
<tr>
<td>6-12 months old</td>
<td>29.6%</td>
<td>19.79%</td>
</tr>
<tr>
<td>12-15 months</td>
<td>6.8%</td>
<td>7.45%</td>
</tr>
<tr>
<td>Over 15 months old</td>
<td>21%</td>
<td>17.87%</td>
</tr>
</tbody>
</table>

4.3.2 These headline percentages summarise the following position:

- The volume of cases over 12 months old has decreased from 120 at the end of June to 119 at the end of July. These cases represent 25% of our overall caseload. 11 new cases have moved into this category.
- The number of cases over 15 months old has dropped from 88 at the end of June to 84 at the end of July. 8 new cases have moved into this category.
- Out of these 84 cases, 31 are now with the Hearings Team, 14 are with the Case Progression Team, 4 are with the Investigating Committee, and the remaining 35 are with the Investigation Team.

4.4 **Target to close 95% of all FtP cases within 12 months**

4.4.1 In July 83% of cases that were closed, were closed within **12 months**. Between August 2012 and July 2013, 83% of cases that were closed, were closed within **12 months**.

4.5 **Cases over 15 months**

4.5.1 Our oldest case is 44 months old. Of all cases over 15 months old, the average case age is 22 months, while the median is 21 months. The age profile of case over 15 months is set out in Table 3 below. There tend to be a wide variety of case specific reasons for delays in the progression of cases. Some common causes include those cases involving investigations by other regulators or enforcement bodies, health reasons and in the canvassing of dates.
Table 3

<table>
<thead>
<tr>
<th>Age profile of cases &gt; 15 months</th>
<th>Jul-13</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20 Months</td>
<td>42</td>
<td>50.00%</td>
</tr>
<tr>
<td>20-25 months</td>
<td>23</td>
<td>27.38%</td>
</tr>
<tr>
<td>25-30 months</td>
<td>8</td>
<td>9.52%</td>
</tr>
<tr>
<td>31-35 months</td>
<td>7</td>
<td>8.33%</td>
</tr>
<tr>
<td>40-44 months</td>
<td>4</td>
<td>4.76%</td>
</tr>
</tbody>
</table>

4.5.2 We have seven open legacy cases; 4 of these cases are with the hearings team - 1 case has been listed for a principal hearing in September while the remaining 3 are being canvassed to be listed for hearing. 2 cases are with the case progression team, one of these cases is awaiting disclosure while the other case is being considered for a direct referral to the Fitness to Practise Committee. 1 case is with the Investigating Team awaiting a coroner’s inquest to take place.

4.6 Fitness to Practise Activity August 2012 to July 2013

4.6.1 Table 4 below sets out a summary of the data set used by the Professional Standards Authority (PSA) to monitor the timeliness of the GPhC’s fitness to practice activity. This covers the performance for the year August 2012 to July 2013 and compares favourably with the performance delivered in 2011. Under all measures there has been continuous improvement, with reductions across the board in the timeliness of case handling in fitness to practise.

Table 4 - Fitness to Practise Activity

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>August 2012 to July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median time taken from receipt of initial complaint to final fitness to practise hearing determination</td>
<td>126 weeks</td>
<td>110 weeks</td>
</tr>
<tr>
<td>The median time taken from receipt of initial complaint to final investigating committee decision</td>
<td>65 weeks</td>
<td>51 Weeks</td>
</tr>
<tr>
<td>The median time taken from final investigating committee decision to final fitness to practise hearing decision</td>
<td>91 weeks</td>
<td>36 weeks</td>
</tr>
</tbody>
</table>
4.7 Statutory appeals

4.7.1 During this period one appeal case was successfully concluded. We presently have two outstanding appeals both of which are listed for hearing in the High Court during November 2013.
5. Organisational Feedback

This section reports on the feedback received about the way in which the organisation carries out its work. It covers complaints made against the workings of the GPhC as an organisation (as opposed to complaints about registrants) and provides a summary of the positive feedback we’ve received.

5.1 Introduction

5.1.1 At its meeting on 13 June 2013, the Council asked for the complaints report to show quarterly statistics and to also include the previous year’s figures for comparison. This report sets out this new reporting format.

5.1.2 As complaints data will now be presented on a quarterly basis, Council is asked to note the revised schedule for reporting complaints data as set out below:

- Jan – Mar > Jun Council
- Apr – Jun > Sept Council
- Jul – Sept > Nov Council
- Oct – Dec > Feb Council

5.1.3 Changing the reporting schedule in this way will mean that there will not be a complaints report to Council at its meeting in April.

5.1.4 It is also proposed that the annual ‘Handling Organisational Complaints’ report is presented to the Council in June; it is currently scheduled for February. Changing the timing in this way will allow for Council to receive the complaints statistics and analysis for the same reporting period as for our Annual Report.

5.2 Total number of complaints

5.2.1 Table 1 below shows the total number of complaints received for the last quarter. The figures in brackets show figures for the same reporting period last year which show that the overall total number of complaints received remains the same.

5.2.2 Table 2 provides a breakdown of the total number of formal complaints received against the three stages of the formal complaints process. It shows there was a minor increase in the number of second stage complaints.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>1 Apr - 30 Jun 2013 (same period last year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of complaints received</td>
<td>30 (30)</td>
</tr>
</tbody>
</table>
Table 2

<table>
<thead>
<tr>
<th>Formal complaints received</th>
<th>1 Apr - 30 Jun 2013 (same period last year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>7 (5)</td>
</tr>
<tr>
<td>Stage 2</td>
<td>2* (0)</td>
</tr>
<tr>
<td>Stage 3</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

*The figures in brackets show figures for the same reporting period last year

5.3 Breakdown by theme/category

5.3.1 Table 3 below shows a breakdown by complaint theme/category. Some complaints address more than one issue, these are split by theme/category and each issue is recorded.

Table 3

<table>
<thead>
<tr>
<th>Complaint theme/category</th>
<th>1 Apr - 30 Jun 2013 (same period last year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of communication/information</td>
<td>12 (13)</td>
</tr>
<tr>
<td>Accuracy of recorded information</td>
<td>10 (4)</td>
</tr>
<tr>
<td>Delays</td>
<td>9 (9)</td>
</tr>
<tr>
<td>Failure to respond</td>
<td>5 (0)</td>
</tr>
<tr>
<td>Complaints handling</td>
<td>4 (1)</td>
</tr>
<tr>
<td>Outcome/GPhC decision</td>
<td>4 (1)</td>
</tr>
<tr>
<td>GPhC policy/process</td>
<td>2 (12)</td>
</tr>
<tr>
<td>Staff conduct</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

5.3.2 Issues relating to registration make up the largest proportion of complaints received. These were mainly about the administration of the registration/renewal process. There were also some concerns regarding our communication in relation to the restoration process and in particular the rules around returning to the register within one year of being voluntarily removed.

5.3.3 Other repeat feedback received relate mainly to concerns raised about administrative errors with recording CPD entries. Of the 6,460 CPD submissions over the last quarter we received 5 CPD related complaints. The issues raised related to requesting CPD records from registrants in error (where registrants

* One of the second stage complaints was treated as a second stage complaint as the enquirer had been dealing with a Director so the response was sent directly from the Director rather than the Complaints Manager.
had already submitted their records) and poor guidance on how to submit records.

5.3.4 We also received some feedback about administrative errors with setting up direct debit payments. Of the 4,457 direct debit payments that were taken over the last quarter we received 4 complaints regarding failures with taking direct debit payments. We recognise the constraints with our current direct debit process which is a manual process and set-up of payments must keep within the renewal parameters of declarations and payment. Our long term IT strategy will explore the option of paperless direct debits.

5.4 Positive feedback

5.4.1 In the reporting period, we also received 8 compliments about our work. These include the comprehensiveness of the advice provided by the standards advisory team and the helpful approach by staff in the customer contact centre.
6. Financial Performance

The financial data provide an overview of the financial performance of the GPhC as at 31 July 2013.

6.1 Comparative data

6.1.1 The actual results are compared against the reforecast completed at the end of the 1st quarter.

6.2 Year to date

6.2.1 The operating surplus (after tax and interest) for the four months to 31 July was £1,046k, which was £262k above reforecast. Total income was £6,872k and total expenditure was £5,927k.

6.2.2 Income was £94k (1%) above reforecast, mainly owing to the receipt of application fees following the June exams. Previous experience has been that the fees were received in August. Expenditure was £166k (3%) below reforecast, as a result of savings on Employee Costs (posts not filled and savings on temporary staff) and Professional Fees (delays in appointing IT consultants and savings on legal fees).

6.3 Balance sheet

6.3.1 As at 31 July the total assets / funds of the GPhC amounted to £15.7m. The target reserve level for the GPhC is £12.5m.

6.3.2 Net Current Assets were £15.4m, an increase of £3.9m since 31 July 2012.
## General Pharmaceutical Council

### Management Accounts July 2013 - Breakdown by cost type

<table>
<thead>
<tr>
<th></th>
<th>July 2013</th>
<th>Year to date</th>
<th>Forecast to 31/03/14</th>
<th>Budget to 31/03/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Forecast</td>
<td>Variance</td>
<td>Variance</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pharmacists</td>
<td>1,119,065</td>
<td>1,007,566</td>
<td>111,499</td>
<td>4,052,628</td>
</tr>
<tr>
<td>- Premises</td>
<td>304,318</td>
<td>276,478</td>
<td>27,840</td>
<td>1,165,971</td>
</tr>
<tr>
<td>- Technicians</td>
<td>216,581</td>
<td>209,936</td>
<td>6,645</td>
<td>846,265</td>
</tr>
<tr>
<td>- Pre-Registration</td>
<td>32,161</td>
<td>31,240</td>
<td>921</td>
<td>599,700</td>
</tr>
<tr>
<td>- Other</td>
<td>59,033</td>
<td>111,710</td>
<td>(52,677)</td>
<td>205,518</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>1,731,157</td>
<td>1,636,930</td>
<td>94,227</td>
<td>6,870,082</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Employee Costs</td>
<td>(914,125)</td>
<td>(946,167)</td>
<td>32,042</td>
<td>(3,685,956)</td>
</tr>
<tr>
<td>- Property Costs</td>
<td>(17,467)</td>
<td>(19,470)</td>
<td>2,003</td>
<td>(71,473)</td>
</tr>
<tr>
<td>- Office Costs</td>
<td>(78,330)</td>
<td>(83,123)</td>
<td>4,793</td>
<td>(248,626)</td>
</tr>
<tr>
<td>- Professional Costs</td>
<td>(193,144)</td>
<td>(260,705)</td>
<td>67,561</td>
<td>(746,380)</td>
</tr>
<tr>
<td>- Event Costs</td>
<td>(19,842)</td>
<td>(30,366)</td>
<td>10,524</td>
<td>(219,090)</td>
</tr>
<tr>
<td>- Marketing Costs</td>
<td>(64,890)</td>
<td>(65,908)</td>
<td>1,019</td>
<td>(148,123)</td>
</tr>
<tr>
<td>- Research Costs</td>
<td>0</td>
<td>(16,267)</td>
<td>16,267</td>
<td>(7,163)</td>
</tr>
<tr>
<td>- MIS Costs</td>
<td>(41,372)</td>
<td>(39,473)</td>
<td>(1,899)</td>
<td>(130,124)</td>
</tr>
<tr>
<td>- Other Costs</td>
<td>(4,248)</td>
<td>(29,508)</td>
<td>25,261</td>
<td>(14,657)</td>
</tr>
<tr>
<td>- Occupancy &amp; Service Level Costs</td>
<td>(148,900)</td>
<td>(151,747)</td>
<td>2,847</td>
<td>(592,937)</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td>(1,495,725)</td>
<td>(1,659,799)</td>
<td>164,074</td>
<td>(5,924,418)</td>
</tr>
<tr>
<td>- Corporation Tax</td>
<td>(4,170)</td>
<td>(6,393)</td>
<td>2,224</td>
<td>(25,916)</td>
</tr>
<tr>
<td>- Interest Receivable</td>
<td>31,282</td>
<td>31,500</td>
<td>(218)</td>
<td>125,849</td>
</tr>
<tr>
<td><strong>Surplus / (Deficit)</strong></td>
<td>262,544</td>
<td>2,237</td>
<td>260,307</td>
<td>1,045,597</td>
</tr>
</tbody>
</table>

09.13/C/06 Page 31 of 40
## Management Information Report 2013/14

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>£'000</th>
<th>Var £'000</th>
<th>Var %</th>
<th>No.</th>
<th>£'000</th>
<th>£'000</th>
<th>%</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td>47,394</td>
<td>4,052</td>
<td></td>
<td>111</td>
<td>2.8</td>
<td>49,299</td>
<td>12,463</td>
<td>95</td>
<td>0.8</td>
</tr>
<tr>
<td>Technicians</td>
<td>21,967</td>
<td>846</td>
<td></td>
<td>7</td>
<td>0.8</td>
<td>21,834</td>
<td>2,523</td>
<td>110</td>
<td>4.6</td>
</tr>
<tr>
<td>Premises</td>
<td>14,270</td>
<td>1,166</td>
<td></td>
<td>28</td>
<td>2.4</td>
<td>14,196</td>
<td>3,336</td>
<td>80</td>
<td>2.5</td>
</tr>
<tr>
<td>Pre-registants</td>
<td>5,728</td>
<td>600</td>
<td></td>
<td>1</td>
<td>0.2</td>
<td>1,012</td>
<td>24</td>
<td>24</td>
<td>2.4</td>
</tr>
<tr>
<td>Other income</td>
<td>208</td>
<td>(53)</td>
<td></td>
<td>-20.3</td>
<td></td>
<td>1,112</td>
<td>(126)</td>
<td>-10.2</td>
<td>1,238</td>
</tr>
<tr>
<td></td>
<td>6,872</td>
<td>94</td>
<td></td>
<td>1.4</td>
<td></td>
<td>20,446</td>
<td>183</td>
<td>0.9</td>
<td></td>
</tr>
</tbody>
</table>

### Expenditure

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>£'000</th>
<th>Var £'000</th>
<th>Var %</th>
<th>No.</th>
<th>£'000</th>
<th>£'000</th>
<th>%</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy &amp; Communications</td>
<td>(1,032)</td>
<td>47</td>
<td></td>
<td>4.4</td>
<td>(3,628)</td>
<td>(370)</td>
<td>-11.4</td>
<td>(3,258)</td>
<td></td>
</tr>
<tr>
<td>Regulatory Services</td>
<td>(2,623)</td>
<td>(12)</td>
<td></td>
<td>-0.5</td>
<td>(8,319)</td>
<td>(329)</td>
<td>-4.1</td>
<td>(7,990)</td>
<td></td>
</tr>
<tr>
<td>Support Costs</td>
<td>(2,272)</td>
<td>179</td>
<td></td>
<td>5.4</td>
<td>(7,531)</td>
<td>214</td>
<td>2.8</td>
<td>(7,745)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5,927)</td>
<td>164</td>
<td></td>
<td>2.7</td>
<td>(19,478)</td>
<td>(485)</td>
<td>-2.6</td>
<td>(18,993)</td>
<td></td>
</tr>
</tbody>
</table>

### Interest net of Corporation Tax

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>£'000</th>
<th>Var £'000</th>
<th>Var %</th>
<th>No.</th>
<th>£'000</th>
<th>£'000</th>
<th>%</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Surplus after tax</td>
<td>100</td>
<td>2</td>
<td></td>
<td>2.0</td>
<td>301</td>
<td>190</td>
<td>171.2</td>
<td></td>
<td>111</td>
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### Support costs as a percentage of total income

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>£'000</th>
<th>Var £'000</th>
<th>Var %</th>
<th>No.</th>
<th>£'000</th>
<th>£'000</th>
<th>%</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Sheet</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Capital Expenditure</td>
<td>84</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank &amp; Cash</td>
<td>26,139</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred Income</td>
<td>(10,436)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Current Assets</td>
<td>15,422</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserves</td>
<td>15,665</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

---

**Key**

Income on or above budget. Expenditure below budget.
Income up to 2.5% below budget. Expenditure up to 2.5% over budget.
Income more than 2.5% below budget. Expenditure more than 2.5% above budget.

16/08/2013
<table>
<thead>
<tr>
<th></th>
<th>July 2013</th>
<th>March 2013</th>
<th>July 2012</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible Assets</td>
<td>242</td>
<td>206</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>242</td>
<td>206</td>
<td>159</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
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<tr>
<td>Trade Debtors</td>
<td>3</td>
<td>29</td>
<td>74</td>
</tr>
<tr>
<td>Other Debtors</td>
<td>201</td>
<td>417</td>
<td>17</td>
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<tr>
<td>Prepayments</td>
<td>568</td>
<td>574</td>
<td>331</td>
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<tr>
<td>Accrued Income</td>
<td>164</td>
<td>40</td>
<td>160</td>
</tr>
<tr>
<td>Bank &amp; Cash</td>
<td>26,139</td>
<td>28,868</td>
<td>23,409</td>
</tr>
<tr>
<td></td>
<td>27,075</td>
<td>29,928</td>
<td>23,992</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
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<tr>
<td>Trade Creditors</td>
<td>528</td>
<td>584</td>
<td>424</td>
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<td>Corporation Tax</td>
<td>70</td>
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<td>Other Creditors</td>
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<td>56</td>
<td>15</td>
</tr>
<tr>
<td>Other Taxes &amp; Social Security</td>
<td>0</td>
<td>198</td>
<td>0</td>
</tr>
<tr>
<td>Deferred Income :-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Grants</td>
<td>1,517</td>
<td>1,640</td>
<td>2,065</td>
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<td>- Ring Fenced Grant</td>
<td>76</td>
<td>76</td>
<td>76</td>
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<tr>
<td>- DH Grants</td>
<td>7</td>
<td>7</td>
<td>22</td>
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<tr>
<td>- Fee Income</td>
<td>8,832</td>
<td>12,368</td>
<td>8,895</td>
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<tr>
<td>- Other Income</td>
<td>4</td>
<td>7</td>
<td>4</td>
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<tr>
<td>Accruals</td>
<td>617</td>
<td>511</td>
<td>981</td>
</tr>
<tr>
<td></td>
<td>11,652</td>
<td>15,492</td>
<td>12,482</td>
</tr>
<tr>
<td><strong>Net Current Assets / (Liabilities)</strong></td>
<td>15,423</td>
<td>14,436</td>
<td>11,509</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>15,665</td>
<td>14,642</td>
<td>11,668</td>
</tr>
<tr>
<td><strong>Funds Employed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated Fund b/fwd.</td>
<td>14,642</td>
<td>9,845</td>
<td>9,846</td>
</tr>
<tr>
<td>Surplus/(Deficit) in Year</td>
<td>1,036</td>
<td>4,797</td>
<td>1,822</td>
</tr>
<tr>
<td>Prior Year Adjustment</td>
<td>(13)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Funds</strong></td>
<td>15,665</td>
<td>14,642</td>
<td>11,668</td>
</tr>
</tbody>
</table>
Appendix 2 –

Board of Assessors

Report to the General Pharmaceutical Council
Registration Assessment June 2013

1. Introduction

1.1 The initial education and training of pharmacists in Great Britain is:
   • an accredited four-year MPharm degree\(^3\); then
   • 52 weeks of pre-registration training; and
   • the GPhC’s Registration Assessment.

1.2 During pre-registration training, trainees are signed-off on four occasions by their tutor – at 13, 26, 39 and 52 weeks. Trainees must have been signed off as ‘satisfactory’ or better at 39 weeks to be eligible to enter for a sitting of the Registration Assessment.

1.3 Candidates with a specific need may ask for an adjustment to be made in the conduct of the assessment. Candidates with specific needs may sit the assessment in a separate adjustments room.

1.4 The Registration Assessment is a multiple choice questions examination with two papers: a morning closed book paper and an afternoon open book paper. In the closed book paper, no reference sources can be used; in the open book paper, specified reference sources can be used. Calculators are not permitted.

1.5 There are 90 questions in the closed book paper, to be answered in 1 hour 30 minutes, and 80 questions in the open book paper, to be answered in 2 hours 30 minutes. The open book paper includes 20 dedicated calculations questions.

2. Reporting to Council

2.1 The Board of Assessors produces two reports for Council annually, one after each sitting of the Registration Assessment.

2.2 This report is the report of the June 2013 sitting.

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\(^3\) Non-EEA pharmacists study on a 1-year Overseas Pharmacists’ Assessment Programme (OSPAP), not an MPharm degree
3. June 2013 statistics

1. Candidate numbers

<table>
<thead>
<tr>
<th>No. of candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of candidates entered</td>
</tr>
<tr>
<td>Number of first sitting candidates</td>
</tr>
<tr>
<td>Number of second sitting candidates</td>
</tr>
<tr>
<td>Number of third sitting candidates</td>
</tr>
</tbody>
</table>

2. Candidate performance 1 - % pass/fail

- Pass: 78%
- Fail: 22%

This pass rate is lower than in June 2012. See below for a discussion of the pass rate.

3. Candidate performance 2 – pass rate by attempt

- 1st Attempt: 80%
- 2nd Attempt: 40%
- 3rd Attempt: 33%

As expected, resit candidates performed less well than first time sitters.
4. **Candidate performance 3 – home students vs OSPAP students**

There is little difference between candidates who studied wholly in GB (‘Home’ candidates) and candidates whose primary pharmacy qualification was gained outside the EEA (‘OSPAP’ candidates).

5. **Candidate performance 4 – performance by gender**

Female candidates performed better than male candidates by 5%.

1576 candidates were female and 863 were male.
6. Candidate performance 5 – performance by country of training

There is a notable difference in performance between countries. There are far more candidates and a greater range of ability in England, which could account for the lower pass rate in that country, but also pre-registration schemes are managed more closely in Wales and Scotland. Practically, this means that there is more uniform support in those countries: for example, in Scotland trainees sit a mock examination before the June sitting, as do managed sector trainees in Wales, and study sessions for trainees are offered in both countries. This is a possible explanation for the two higher pass rates.

7. Candidate performance 6 – first attempt performance by training sector
Note that there were 641 hospital-based candidates, 1701 community-based candidates and that all three of the ‘split’ categories had <50 candidates (which means that pass rates are less reliable than the pass rates for ‘hospital’ and ‘community’). The pass rates confirm that hospital-based candidates performed better than community-based candidates.

Note: ‘Split - Industry’ means 6 months in an industrial setting and 6 months in either hospital or community. ‘Split – Community’ means two 6-month placements, each in a different community setting.

8. Candidate performance 7 – first attempt performance by ethnicity (categories with >100 candidates)

This table presents data on the performance of the main self-designated ethnic categories. Other categories had <100 members and have been excluded on the basis that the data are less reliable for less populous categories.

The performance of ‘Black – African’ candidates is conspicuously lower than for other candidate categories. It should be noted that these candidates are not necessarily candidates who trained overseas, given that the pass rate for OSPAP students is 82%. This would imply that ‘Black – African’ students studying in GB are performing less well than others as a cohort. This will be fed back to schools and pre-registration providers for further investigation.
9. Candidates by centre

<table>
<thead>
<tr>
<th>Location</th>
<th>No. of candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bath</td>
<td>197</td>
</tr>
<tr>
<td>Birmingham</td>
<td>380</td>
</tr>
<tr>
<td>Bradford</td>
<td>225</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>169</td>
</tr>
<tr>
<td>London 1</td>
<td>465</td>
</tr>
<tr>
<td>London 2</td>
<td>374</td>
</tr>
<tr>
<td>London 3</td>
<td>116</td>
</tr>
<tr>
<td>Manchester</td>
<td>330</td>
</tr>
<tr>
<td>Sunderland</td>
<td>126</td>
</tr>
</tbody>
</table>

5. Discussion of the papers by the Board

Routine quality assurance of the paper: After a sitting all questions and the papers as a whole are analysed. As a result of the post-sitting analysis, two questions were removed from the closed book paper (but none were removed from the open book paper). In the case of five questions in the closed book paper and two questions in the open book paper, two answers were accepted for each question, because more than one answer was plausible. This raised the pass rate for all seven questions. This is a greater adjustment than usual but this paper had a larger number of new and untested questions than has been the case for several years. The important point to note is that if a question does not perform as expected, the action taken to mitigate the question’s performance always gives candidates the benefit of the doubt.

Pass mark: The Board considered the pass mark for the Assessment as a whole and also the calculations pass mark and agree that there was no justification for adjusting either.

Comparatively low pass rate: Although the Board was satisfied with the standard of the papers, it did discuss the low pass rate at length. The Board noted a number of points:

1. Using new questions: In every paper some questions are reused and some questions do get into the public domain because candidates memorise them and share them electronically, even though this is not allowed. This is a recognised phenomenon associated with many professional examinations worldwide. As the June 2012 paper drew on questions from the RPSGB’s questions bank, which had a large number of previously used questions, this affected the pass rate (which was high). As soon as the GPhC became responsible for the Registration Assessment it began to commission new questions, which are now being used in papers. This means that those questions could not have been known to candidates, which, the Board believes, has affected the pass rate. The learning point for candidates is that they should not prepare for the Assessment by rote learning answers to old questions.

2. Larger cohorts of candidates: The number of candidates sitting the Assessment has risen significantly in recent years and it is likely that this has affected cohort performance. Not only have some older schools increased their intakes but new schools with different missions and entry requirements are now producing graduates who are sitting the Assessment. Having analysed candidate performance, the Board is concerned that this is
affecting the pass rate. The GPhC has been discussing this matter with schools for several years and will continue to do so.

3. The changing nature of practice: There may be an assumption among candidates that the Assessment does not change – that it does not evolve. The GPhC has made it clear that the Assessment has to change to reflect contemporary practice. This is why the GPhC has issued practice questions and why candidates have been advised to not rely heavily on past papers for revision purposes. The important point to note is that the GPhC has explained to candidates how the paper will be evolving.

Feedback from candidates: The Board takes full account of feedback from candidates at its main meeting. The Board agreed that three comments required a response in this report. They are:

1. The Registration Assessment is used to control entry to the register: This point was made last year so the Board wishes to reiterate, categorically, that the Assessment is not used to control registrant numbers (other than to ensure that all candidates reach the required standard). The Board is an independent body, supported by the GPhC, and has no influence over the GPhC’s registration policy.

2. The Board deliberately sets ambiguous or ‘trick’ questions: This was raised last year and it remains the case that the Board does not deliberately set ambiguous or trick questions. The Board did note that some candidates found it difficult to answer questions requiring a differential judgement: questions such as ‘select the best treatment’ did confuse those candidates, but, the statistics confirmed, often they were candidates who performed less well overall. The point missed by weaker candidates was that other answer options had to be plausible to make the question valid and this meant that while another answer/treatment might have been acceptable, it was not necessarily ‘the best’ treatment, which was the point of the question.

3. Community/hospital bias: Community-based candidates complained that the papers had a hospital bias and hospital-based candidates complained that the papers had a community bias. The comments appear to cancel each other out. When setting questions, the Board always considers whether they are answerable by candidates from both sectors.

Specific learning points for candidates: The Board was concerned about candidate answers for some questions - answers which could have resulted in patient harm in practice. The Board will be issuing separate guidance for candidates about these questions.

Feedback from the BPSA: The BPSA provided feedback to the GPhC on the June 2013 sitting, which was shared with the Board. The GPhC has provided public feedback to the BPSA on the points raised. The Board welcomes input from the BPSA and hopes it will continue to provide useful feedback.

Developing the Registration Assessment: The Board will report to Council on developing the Assessment in its next report.

Board of Assessors
15 August 2013
Professional Standards Authority performance review report 2012-13

Purpose
To provide Council with an update on the Professional Standards Authority (PSA) performance review process.

Recommendations
The Council is asked to note this paper.

1. Performance review 2012-13
1.1 The PSA review report for 2012-13, which contains PSA’s reports on the performance of the nine health and social care professional regulators, was laid before Parliament on 27 June. The report is available at: http://www.professionalstandards.org.uk/docs/scrutiny-quality/performance-review-report-2012-13.pdf?sfvrsn=0

1.2 The PSA assessment is that the GPhC has met all but one of the Standards of Good Regulation. The PSA was unable to confirm whether we have met the 10th Standard of Good Regulation for fitness to practise (information about fitness to practise cases is securely retained) as we were awaiting a ruling from the Information Commissioner’s Office about a data breach that occurred in 2012-13.

1.3 The PSA commended the GPhC’s development of new outcome focused standards for registered pharmacies and assessed the new standards as being compliant with the principles of right-touch regulation.

1.4 The PSA noted that the GPhC has taken action to address problems highlighted in the previous year’s review with the accuracy and timeliness of registration applications for pharmacy technicians.
1.5 In the 2011-12 review the PSA expressed concern about the timeliness of fitness to practise case progression. In this year's report the PSA noted the positive steps the GPhC has taken to address this including:

- Monthly case conference meetings with all investigations staff.
- Team-specific case progression meetings, at which all cases over target timeframes are reviewed to identify and resolve case progression issues.
- The introduction of new investigation and case management procedures.

2. Performance review 2013-14

2.1 The PSA has indicated that it will follow up on a number of issues in the 2013-14 review including:

- The impact of stakeholder engagement activities on developing a new approach to inspections.
- The planned guidance on internet pharmacy/distance selling, the supply of P medicines and the preparation of unlicensed medicines.
- The outcomes from the introduction of the quality assurance function across the fitness to practise process.
- Actions taken in response to the recommendations of the PSA audit of cases closed at the initial stages of the fitness to practise process.
- Actions taken in relation to information security.
- The progress of the work to agree the GPhC’s scheme for continuing fitness to practise in 2015.

2.2 We continually review progress against the commitments we made during 2012-13. In addition, we regularly monitor progress against those issues which the PSA has indicated that it will want to follow up on in the 2013-14 review.

2.3 The evidence submission template for the 2013-14 review will be sent to regulators at the end of September for completion by early December.

3. Equality and diversity implications

3.1 There are no equality and diversity implications raised in this paper.

4. Communications

4.1 We promoted the publication of the PSA performance review report on our website.

5. Resource implications

5.1 There are no resource implications directly associated with this paper or publication of the PSA performance report.

6. Risk implications

6.1 There are reputational risks for the GPhC if we fail to respond adequately to recommendations made by the PSA. We have in place effective monitoring
procedures to ensure we are keeping track of those recommendations and commitments made in our evidence submission.

**Recommendations**

The Council is asked to note this paper.

Duncan Rudkin, Chief Executive & Registrar  
*General Pharmaceutical Council*  
duncan.rudkin@pharmacyregulation.org  
Tel 020 3365 3501

21 August 2013
Revised learning outcomes for the initial education and training of pharmacists

Purpose
To agree a revised set of learning outcomes for the initial education and training of pharmacists

Recommendations
The Council is asked to agree that the new learning outcomes in this paper are contemporary and fit for purpose and should form the basis for a full consultation at a date to be decided.

1. Introduction

1.1 Background - the current standards: In 2009-2010 the former regulator convened a group of academics and pre-registration experts to design a set of standards for the initial education and training of pharmacists. In 2011 they were adopted by the GPhC and became Future pharmacists, standards for the initial education and training of pharmacists.

1.2 Content of the current standards: Each standard deals with a particular aspect of delivery, such as patient safety, equality, diversity & fairness, admissions, teaching, learning & assessment, resources and training & development. Standard 10 is a set of learning outcomes which describe the knowledge and skills gained by a student/trainee at the end of their MPharm degree and at the end of their pre-registration training year.

1.3 Developing revised learning outcomes: In February 2013, Council indentified the need to develop a revised, more contemporary set of learning outcomes and a task and finish group was set up for that purpose. Council agreed that while education standards usually remained in force for a period of 5-6 years, as pharmacy is in a period of particularly rapid change, the current standards are ageing more quickly than usual and are in need of an early revision. In
Council noted the strategic expansion of the clinical role of pharmacists in both hospital and community sectors across Great Britain (GB) and that that had implications for the initial education and training of pharmacists.

1.4 It was agreed that as well as revising the learning outcomes, the contextual material in standards 5 and 10 would also be revised. The contextual material will be presented to Council at a later date, possibly with other revised standards (see 2.5). See Appendix 2 for a summary of other workstreams associated with this work. Note that the timetables for the workstreams rely heavily on the outcome of funding discussions with the Higher Education Funding Council for England (HEFCE) and parallel developments in other GB countries.

1.5 The drafting group: Immediately after the Council’s February 2013 decision to establish a drafting group, one was established. It met on three occasions and new learning outcomes were drafted for consideration by Council (see Appendix 3).

1.6 The group was chaired by Mr Nigel Clarke and comprised academics nominated by the Pharmacy Schools Council (PhSC), pre-registration experts, a British Pharmaceutical Students’ Association representative, recently registered pharmacists and a lay member with an interest in patient and public issues and knowledge of the current education standards for pharmacists. Members were drawn from all three GB countries. Members were invited to join the group on the basis that they have recent experience of writing or using learning outcomes.

1.7 The GPhC’s country directors observed the group’s work as did representatives from Health Education England (HEE) and the Pharmaceutical Society of Northern Ireland (PSNI).

1.8 See Appendix 1 for the group’s membership.

2. Key considerations

2.1 The scope of the work: based on the decisions by Council, the group was asked to consider and design new learning outcomes for the initial education and training of pharmacists. This remit involved looking at possible revisions to current Standard 5 (curriculum delivery and student experience) and Standard 10 (outcomes) of Future Pharmacists.

2.2 In considering how to meet this objective the drafting group sought expert input on health policy, pharmacy policy and pharmacy education policy in England, Scotland and Wales. Other key documents considered were HEE’s strategic intent statement, the NHS Constitution and the report of the Francis Inquiry. This context setting helped to ensure key topics, for example feedback on the importance of patient voice, professionalism and raising concerns were considered by the group.

2.3 Drafting the revised learning outcomes: After scoping the work, the drafting task was delegated to Professor David Wright, Chair in Pharmacy Practice at the University of East Anglia. He translated the group’s wide ranging discussions
into a revised set of outcomes, which was then considered, line by line, by the drafting group. For each outcome, a set of accompanying expectations was written to describe in more detail how the outcomes may be applied.

2.4 The structure and content of the new learning outcomes: Although the majority of the content from the existing learning outcomes has been retained, the group felt that the structure and presentation of the learning outcomes could be improved significantly. To describe the role of the contemporary pharmacist clearly, and to structure the learning outcomes coherently, they have been grouped under four domains:

- Pharmacist as professional
- Pharmacist as scientist and researcher
- Pharmacist as leader and manager
- Pharmacist as clinician and prescriber

2.5 Council should note that the themes strengthened in these learning outcomes are patient and public protection, patient-centred care, professionalism, inter-professionalism, the managerial/leadership role and the clinical role of the pharmacist. The scientist and researcher domain re-emphasises the critical role of science and research to pharmacy.

2.6 Council should note that the outcomes set out in the current standards for the initial education and training of pharmacists are broken down into outcomes at the end of the MPharm and outcomes at the end of the pre-registration year. The group felt, given the Council’s focus on outcomes which would lead to registration, it would be appropriate to describe the new learning outcomes across the five years of pre-registration education and training. Each learning outcome has to be met at the level specified – knows, knows how, shows how, or does - at the end of five years, whatever the model and mode of delivery. The model and mode may vary between countries.

2.7 Initial feedback on the revised learning outcomes: The revised learning outcomes have been scrutinised already by a group of academics nominated by PhSC (see Appendix 1 for membership). Subject to minor revisions, which have been made, the group agreed that the revised learning outcomes were fit for purpose and should be considered by Council. The group was authorised by PhSC to speak on its behalf.

2.8 The group raised three specific issues about the delivery of the revised learning outcomes:

- that not all current pre-registration tutors have the necessary skills to help deliver the new learning outcomes and may have to undergo training if they are to retain their tutoring role;
- a wider point linked to the previous one is that some community pharmacies are not equipped to deliver the new learning outcomes and will need support if they are to do so; and
- that regional quality management and support networks such as ‘deaneries’ will be key to supporting tutors (and trainees, of course).
2.9 These legitimate points will be dealt with in new regulatory standards for organisations fulfilling the role of ‘deaneries’, which is where the responsibility for supporting tutors and training premises should eventually lie. Preliminary drafting of these standards will begin in early 2014.

2.10 In addition to the scrutiny group, the learning outcomes have been shared with the chief pharmaceutical officers, Health Education England, the Higher Education Funding Council for England, the Scottish Funding Council, the Higher Education Funding Council for Wales, all UK schools of pharmacy, the NHS Pharmacy Education and Development Committee (representing the managed sector), Boots and Lloyds.

2.11 Advice to Council from the drafting group: As the group developed the learning outcomes and considered standards 5 and 10 they noted that changes to other standards should, in their view, be considered in due course. The group felt this was true particularly for Standard 4 ‘Selection of students and trainees’, for example. As currently written the standard emphasises fairness and openness in selection but the importance of professional suitability is, perhaps, underplayed.

2.12 The group asked for the general comment to be passed on to Council.

2.13 Delivering the learning outcomes: At the time the current standards were drafted, the MPharm degree attracted Band B funding from HEFCE and its equivalents in Scotland and Wales. Band B is a funding band for scientific subjects. There is a higher band of funding, ‘A’, for clinical subjects but pharmacy could not and cannot currently access it. For this reason, some desirable clinical outcomes were not included in the current standards because there was a concern that they could not be delivered effectively with only the lower level funding.

2.14 It remains the case that MPharm degrees attract only Band B funding, and its equivalents in Scotland and Wales.

2.15 Since the current standards were implemented, there have been proposals for changes to the structure and funding of the initial education and training of pharmacists in the GB countries:

- The Modernising Pharmacy Careers programme in England has submitted proposals to English ministers for a five-year integrated degree including blocks of pre-registration training. The proposals have been accepted in principle, subject to funding matters being resolved; and
- There are equivalent proposals under discussion in Scotland and Wales, although those discussions are not so far advanced. The GPhC recognises that the implementation solutions for the new learning outcomes in Scotland and Wales may differ from England’s, but is committed to implementing them in a way that is sufficiently flexible to accommodate variation between countries.

2.16 From the outset Council has made clear that the decision to commission a review of learning outcomes is as a result of changing requirements, including
the need for enhanced clinical skills of pharmacists, both in community settings and hospital settings.

2.17 External developments across GB in relation to the structure and funding of pharmacy education are key considerations for Council in relation to its decision about timing for implementation of the standards.

2.18 The discussions of the learning outcomes group were not based on any presumption about final decision on changes to the structure and funding of pharmacist education, but on the remit given to the group to consider how the learning outcomes could be enhanced to reflect the changing requirements on pharmacists mentioned above.

2.19 Any structural and funding changes are directly relevant to any future decision of Council’s to the implementation of the revised learning outcomes presented in this paper.

**Next steps:**

2.20 The Department of Health is convening a group to consider the delivery implications of the new learning outcomes (its curriculum delivery group). Their recommendations will be put to HEFCE so that a case for clinical funding for the MPharm degree can be considered. Equivalent discussions are likely to be held in due course in Scotland and Wales.

2.21 The GPhC will continue to discuss its education standards development work with the devolved administrations and PSNI as their pharmacy education reform plans develop and mature.

2.22 The GPhC will consult fully on the new learning outcomes once the outcomes of discussions about delivery and funding in all three GB countries are clearer;

2.23 Other workstreams associated with this work are listed in Appendix 2.

3. **Equality and diversity implications**

3.1 The principles of equality and diversity are central to the current standards and will remain central to the revised standards.

4. **Communications implications**

4.1 To date, the learning outcomes have been shared with key stakeholders (see 2.4). Once the GPhC is in a position to tell whether implementing them is possible, a public consultation will take place. The timetable for this consultation is indeterminate at the moment.

5. **Resource implications**

5.1 **Short term:** The cost of drafting the learning outcomes has been borne by the GPhC from existing budgets.

5.2 **Long term:** Changes to the delivery of the initial education and training of pharmacists will require a restructuring of the GPhC’s education & registration
policy and pre-registration functions. This will include a re-evaluation of the current approach to, and scope of, accreditation - specifically in relation to the accreditation of ‘deanery’ functions. Preliminary discussions about this have taken place internally.

6. **Risk implications**

6.1 There is one substantial risk associated with implementing these new learning outcomes: if delivery structures and funding mechanisms cannot be agreed, it might not be possible to implement them. To minimise the risk of this happening, the GPhC will participate in discussions about delivery and funding in a manner consistent with its role and remit.

**Recommendations**

The Council is asked to agree that the new learning outcomes in this paper are contemporary and fit for purpose and should form the basis for a full consultation at a date to be decided.

Damian Day, Head of Education & Registration Policy

*General Pharmaceutical Council*

damian.day@pharmacyregulation.org, tel 020 3365 3455

22 August 2013
Appendix 1

Learning Outcomes Review Group Membership

Mr Nigel Clarke  **Chair**, consultant, chair of Transcom (the group tasked with making proposals for a new professional body for pharmacy (now the RPS)) and former chair of the General Osteopathic Council

**Members**

Professor Graham Davies  Professor in Clinical Pharmacy and Therapeutics, King’s College London (Pharmacy Schools Council (PhSC) nominee)

Mrs Ruth Edwards  MPharm Course Leader/Senior Lecturer in Pharmacy, School of Pharmacy and Life Sciences, The Robert Gordon University, Aberdeen (PhSC nominee)

Professor Barrie Kellam  Associate Professor in Pharmaceutical Medicinal Chemistry, School of Pharmacy, University of Nottingham (PhSC nominee)

Dr Adrian Hunt  Deputy Head, School of Pharmacy and Biomedical Sciences, University of Portsmouth (PhSC nominee)

Mrs Janet Gilbertson  All Wales Principal Pharmacist, MPC Wales

Ms Michele Sehrawat  All Wales Principal Pharmacist (alternate for Janet Gilbertson)

Ms Amanda Kemp  Regional Pre-registration Facilitator, East Midlands

Professor Rose Marie Parr  NHS Education Scotland, Director for Pharmacy

Ms Lauren Rose  Vice President, British Pharmaceutical Students’ Association

Mr Owen Wood  Community Pharmacist, Pharmacy Manager, Manor Pharmacy Group, registered 2012

Mr Shahzad Ahmad  Relief Pharmacy Manager, South West Region, Lloyds Pharmacy, registered 2012

Ms Raminder Sihota  Learning and Development Manager, Boots

Ms Leonie Milliner  Chief Executive, Association for Nutrition, lay member
Drafter

Professor David Wright  
**Drafter**, Chair in Pharmacy Practice, University of East Anglia

Observers

Dr Sue Ambler  
Head of Education and Training, Health Education England

Mr Brendan Kerr  
Registrar and Head of Regulatory Services, PSNI

Mr Peter McKee  
Pre-registration lead, PSNI (alternate for Brendan Kerr)

Mr Darren Hughes  
GPhC Director for Wales

Ms Lynsey Cleland  
GPhC Director for Scotland

Secretariat

Mr Damian Day  
Head of Education and Registration Policy, GPhC

Mr Paul Stern  
Education Policy Officer, GPhC, project lead

PhSC Scrutiny Group Membership

Professor Kay Marshall  
Professor of Reproductive Endocrine Pharmacology and Head of the Manchester Pharmacy School, University of Manchester

Professor Larry Goodyer  
Professor of Pharmacy Practice and Head of the Leicester School of Pharmacy, De Montfort University

Dr Jessica Clemerson  
Senior Lecturer in Pharmacy Practice & Clinical Therapeutics, University of Sunderland

Professor Helen Osborn  
Professor of Biomedicinal Chemistry and Head of the Department of Pharmacy, University of Reading

Secretariat

Ms Naomi Drinkwater  
Senior Policy Officer, Pharmacy Schools Council

In attendance

Professor David Wright, Mr Damian Day, Mr Paul Stern
### Appendix 2

**Workstreams associated with the work of the learning outcomes revision group**

<table>
<thead>
<tr>
<th>What</th>
<th>By whom</th>
<th>When (subject to the timetable of the first workstream)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum delivery group. To establish what additional resources are required to deliver the new outcomes.</td>
<td>DH-convened group</td>
<td>Timetable to be determined by the DH</td>
</tr>
<tr>
<td>Revised Standard 5 and contextual narrative for Standard 10</td>
<td>Completed by drafting group, to be edited by the GPhC</td>
<td>Autumn 2013</td>
</tr>
<tr>
<td>Revise other standards, particularly Standard 4, <em>Selection of students and trainees</em></td>
<td>GPhC to have initial discussions with stakeholders then draft standards for consultation</td>
<td>Mid 2014</td>
</tr>
<tr>
<td>If a 5-year course is introduced, subsidiary outcomes linked to pre-registration training blocks will need to be drafted</td>
<td>GPhC to convene a working group</td>
<td>Late 2014</td>
</tr>
<tr>
<td>The new learning outcomes should equip students with the knowledge and skills (but not experience) to work as supplementary prescribers. The additional experience needed to be annotated as supplementary prescribers needs to be determined.</td>
<td>A working group has been convened to redraft standards for prescribing - this task will be added to the group's work</td>
<td>2014</td>
</tr>
</tbody>
</table>
| GPhC Standards for organisations delivering 'deanery' functions. To include:  
  - Standards for the organisation  
  - Standards for the delivery of pre-registration training programmes  
  - Standards for the training, assessment and quality assurance of trainees  
  - Standards for the training, evaluation and quality assurance of tutors  
  - Standards for the quality assurance of training premises | GPhC                                          | Initial work in late 2013 with more substantive working out in 2014 |
<p>|                                                                       | NB The number of ‘deanery’ organisations will be determined by the DH but the GPhC is assuming that NES will be the Scottish deanery and that there will be one ‘deanery’ in Wales |                                                       |</p>
<table>
<thead>
<tr>
<th>What</th>
<th>By whom</th>
<th>When (subject to the timetable of the first workstream)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Assessment: To consider a number of issues:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Its placement in the 5 years of initial education and training</td>
<td>GPhC</td>
<td>2013 onwards</td>
</tr>
<tr>
<td>• Its format (MCQ, OSCE, both?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Its mode of delivery (pen and paper, observation, online)</td>
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</table>
Appendix 3

Revised learning outcomes for the initial education and training of pharmacists (2013)

Contents

Domain 1: Pharmacist as a Professional ................................................................. 2
Domain 2: Pharmacist as a Scientist and Researcher ........................................... 6
Domain 3: Pharmacist as a Leader and Manager .................................................. 9
Domain 4: Pharmacist as a Clinician and Prescriber ........................................... 13
## Domain 1: Pharmacist as a Professional

### 1.1
**Outcome:** Demonstrates the values of the profession.  
**Outcome Level:** Does

**Expectations:**
Operates within regulatory and professional standards including the GPhC Standards of Conduct, Ethics and Performance and NHS values. Demonstrates appropriate professional attitudes, care and compassion when delivering patient centred care. Seeks to enhance the profession by engaging with the wider profession including professional bodies.

### 1.2
**Outcome:** Applies professional judgement in the best interests of the patient and the public.  
**Outcome Level:** Does

**Expectations:**
Makes professional judgements in a systematic and reasoned way, respecting the rights of all involved. Recognises ethical dilemmas and responds appropriately. Understands and applies GPhC standards and principles for professional conduct. Demonstrates care and compassion to deliver patient centred care. Demonstrates accountability in decision making and is able to justify decisions made in the context of patient or public safety.

### 1.3
**Outcome:** Takes personal responsibility for health and safety of self, staff, patients and the public, and follows up any concerns about the workplace which might put them at risk.  
**Outcome Level:** Does

**Expectations:**
Puts safety of patient and public above all other interests. Recognises potential health and safety issues, raises concerns safely and confidently, and takes action quickly and comprehensively including whistleblowing. Demonstrates an understanding of health and safety legislation, workplace standards, COSHH standards, and risk assessments. Takes responsibility for safety within working environment, ensuring risks are managed to minimise risk. Demonstrates knowledge of the methods to report concerns, whom to report to and the appropriateness of doing so.

### 1.4
**Outcome:** Practices effectively in different environments, respecting privacy and managing risk to self and others.  
**Outcome Level:** Does

**Expectations:**
Identifies and is able to adapt to the challenges of working in different environments, such as patient’s home, e-pharmacy and medical practice and responds appropriately i.e. implements lone worker policy, respects patient privacy, knows when honorary contracts required.
### Domain 1: Pharmacist as a Professional

<table>
<thead>
<tr>
<th><strong>1.5</strong></th>
<th><strong>Outcome:</strong></th>
<th><strong>Outcome Level:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respects others and applies the principles of equality and diversity in all actions.</td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Respects the views of others when supporting decision making. Respects patient choice and preference and considers this when making decisions relating to their care. Understands the value of and works effectively in a diverse workplace. Recognises different cultures and beliefs and provides services which are sensitive to these. Recognises the need to avoid allowing personal moral and religious beliefs to compromise patient care. Is aware of and up to date on relevant equality and diversity legislation (e.g. <em>Equality Act 2010</em>) and understands how it should be applied and promoted in practice.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>1.6</strong></th>
<th><strong>Outcome:</strong></th>
<th><strong>Outcome Level:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recognises own limitations, works safely and seeks support where appropriate.</td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Recognises when a task or activity is outside of their competence and seeks help from the most appropriate source.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>1.7</strong></th>
<th><strong>Outcome:</strong></th>
<th><strong>Outcome Level:</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Takes responsibility for the legal safe and efficient supply of medicines.</td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Demonstrates the ability to supply medicines with or without a prescription for both humans and animals, whilst operating within current legislation, ensuring safety and accuracy with respect to drug supply and labelling. Makes appropriate records for all actions. Understands and demonstrates accountability for their decisions and actions.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>1.8</strong></th>
<th><strong>Outcome:</strong></th>
<th><strong>Outcome Level:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Effectively reflects on personal and professional approaches to practice to identify learning needs and implements appropriate strategies to enhance performance.</td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Demonstrates an awareness of what they have learnt and how they could, will or have put this into practice (the CPD cycle). Demonstrates an ability to develop personal development plans, identify suitable learning opportunities, apply them and reflect on the experience. Takes ownership of learning and demonstrates ability to independently learn. Actively seeks out and listens to staff and colleagues to obtain feedback on performance. Accepts feedback, reflects and acts on it. Effective critical appraisal of self-performance expected. Does not seek to blame self or others. Can share skills and knowledge with other relevant organisations and professional bodies where appropriate.</td>
<td></td>
</tr>
</tbody>
</table>
### Domain 1: Pharmacist as a Professional

#### 1.9

**Outcome:** Participates in the learning and development of others.  
**Outcome Level:** Does  

**Expectations:**
Demonstrates basic mentoring, coaching, teaching, assessment and appraisal of students, pharmacy team and other healthcare professionals. Is honest and objective when appraising or assessing the performance of others. Leads by example, through commitment, encouragement, compassion and a learning approach.

#### 1.10

**Outcome:** Responds effectively to complaints, incidents and errors and in a manner which demonstrates patient centred care  
**Outcome Level:** Does  

**Expectations:**
Demonstrates an understanding of best practice and standard operating procedures when dealing with complaints, incidents and errors. Demonstrates learning to achieve continual reduction in patient harm. Promote no blame culture of transparency and honesty. Responds appropriately and within relevant professional guidelines. Seeks to address the immediate needs of the patient and relevant others. Makes appropriate records to demonstrate openness, accountability and responsibility.

#### 1.11

**Outcome:** Applies principles of information governance and ensures patient confidentiality.  
**Outcome Level:** Does  

**Expectations:**
Adheres to all the relevant standards and legal rules that apply to information handling and record keeping including the GPhC’s Standards of Conduct, Ethics and Performance and guidance on patient confidentiality. Demonstrates the ability to apply and respond to relevant legislation e.g. Data Protection Act, Access to Health Records Act and Freedom of Information Act.

#### 1.12

**Outcome:** Recognises conflicts of interest and utilises appropriate standards of practice.  
**Outcome Level:** Does  

**Expectations:**
Recognises when interest of a third party may be to the possible detriment of patients and public and takes appropriate steps to address them. Is aware of and applies relevant codes of practice when working with third parties e.g. ABPI Code of Practice.

#### 1.13

**Outcome:** Adapts information and communication to meet the needs of particular audience.  
**Outcome Level:** Does  

**Expectations:**
Identifies patient information needs and presents in a manner which is appropriate to individual
needs. Provides open, honest, accurate and succinct information to patients, carers and healthcare professionals. Communicates in a way that is appropriate to the audience. Includes effective communication of risk versus benefit. Recognises opportunities and constraints associated with providing information from on-line pharmacies and adapts appropriately.

### Domain 1: Pharmacist as a Professional

<table>
<thead>
<tr>
<th>1.14</th>
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</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td><strong>Outcome Level:</strong></td>
</tr>
<tr>
<td>Recognises when the performance of self or others is putting patients or public at risk and responds appropriately.</td>
<td>Shows How</td>
</tr>
</tbody>
</table>

**Expectations:**
Approaches staff performance issues professionally and takes appropriate and proportionate actions. Understands the need to act appropriately when has poor health. Understands the notion of accountability for the services which you provide. Understands whistleblowing and the need to report poor practice by both individuals and institutions. Transparency should be complete, timely and unequivocal. There is an expectation that a practising pharmacist must demonstrate this at ‘Does’ level.
## Domain 2: Pharmacist as a Scientist and Researcher

### 2.1 Outcome: Applies pharmacological principles to the use of medicines.

**Outcome Level:** Does

**Expectations:**
Uses cell and molecular biology, knowledge of endocrine and nervous control systems, pharmacokinetics, pharmacodynamics and pharmacogenomics, to explain and predict how drugs work, interact and cause toxicity. Explains how vaccines are created and used to ensure patient safety and promote utilisation. Utilises knowledge of metabolism processes and pathways to select appropriate drugs, dosages and formulations.

### 2.2 Outcome: Demonstrates how the science of pharmacy is applied in the discovery, design and development of effective and safe medicines and devices.

**Outcome Level:** Shows how

**Expectations:**
Demonstrates detailed and current understanding of drug design, synthesis and discovery processes. Relates process of drug extraction and purification to the safety and efficacy of final product. Effectively relates knowledge of chemical structure, bonding and functional groups to drug absorption, distribution, activity, metabolism and excretion characteristics. Is aware of bioinformatics techniques used within drug design and discovery, and can identify structure activity relationships. Is able to describe the scientific process of and rationale for obtaining a licence before a medicine can be used in patients. Explains current methods of drug testing and development to address patient concerns. Recognises the limitations associated with and safety concerns attributed to the use of unlicensed medicines.

### 2.3 Outcome: Applies pharmaceutical principles to the safe and effective formulation, preparation and packaging of medicines and products.

**Outcome Level:** Shows how

**Expectations:**
Demonstrates ability to develop different pharmaceutical formulations and medical devices utilising detailed and current knowledge of thermodynamics, chemical kinetics and physicochemical properties of drug molecules. Explains formulation and device design process to ensure they are appropriately utilised by patients. Recognises importance of pharmacokinetics in formulation design and relates knowledge to safe and effective use of medicines. Applies knowledge of quality assurance systems used within the pharmaceutical industry to the design and delivery of pharmaceutical services. Utilises knowledge of packaging and labelling science for ensure safe medicines handling, storage and administration.
# Domain 2: Pharmacist as a Scientist and Researcher

## 2.4

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures quality of ingredients to produce and supply safe and effective medicines and products.</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

**Expectations:**
Demonstrates a detailed and current understanding of quality control and assurance procedures and is able to prepare products aseptically utilising effective infection control procedures. Is able to select and utilise appropriate diagnostic tests to ensure quality of ingredients. Recognises role of microbiological contamination in drug stability and device safety and describes processes to minimise this. Performs stability and degradation tests to confirm product stability and shelf life and understands the impact of these parameters on the end user.

## 2.5

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critically evaluates the evidence base to review and enhance delivery of patient services.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Appropriately searches for research evidence surrounding delivery of services. Effectively critiques scientific literature. Utilises evidence for effectiveness and cost-effectiveness to enhance or introduce services. Forms rational evaluations of research and can pull together different sources of information to enhance care. Is aware of the evidence base behind guidelines when making clinical decisions.

## 2.6

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level:</th>
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</thead>
<tbody>
<tr>
<td>Designs and implements effective quality improvement strategies and utilises quality improvement science.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Demonstrates an ability to apply quality improvement strategies including selecting and utilising appropriate clinical audit processes such as standards based audit, service evaluation and critical incident analysis to enhance current service provision.

## 2.7

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributes effectively to research activities.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Designs and conducts research applying appropriate methodology and procedures. Is able to prepare research reports which effectively communicate the rationale for the research methodology and results and considers the possible explanations and implications for these. Communicates results effectively by written and oral report. Adheres strictly to research governance frameworks and protocols, demonstrates an awareness of ethical guidelines and acts appropriately to address any problems which may arise. Operates within employer guidelines. Understands the importance of contributing and engaging with research regardless of sector of employment.
### Domain 2: Pharmacist as a Scientist and Researcher

#### 2.8

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies principles of psychological and social science to enhance patient and population health.</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

**Expectations:**

Describes how health and determinants of health are measured and monitored. Predicts changes in population demographics based on societal structure and development and relates this to the appropriate provision of pharmaceutical services. Explains how health behaviours and outcomes are affected by the diversity of the patient population. Describes how sociological and psychological concepts of health, illness and disease and related theoretical frameworks can be used to both explain and improve patient health related behaviours. Describes sociological and psychological determinants of health (e.g. health inequalities) and how pharmaceutical services can be tailored to address these.

#### 2.9

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectively manages infectious diseases through application of microbiological science.</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

**Expectations:**

Classifies and identifies bacteria, fungi, viruses, protozoa and helminthes to enable appropriate selection of antimicrobial treatment and prevention strategies. Explains treatment effectiveness and rationale for disease prevention strategies through the knowledge of antimicrobial lifecycles, pathogenicity and epidemiology. Describes how disease transfers from animals to humans to enable preventative strategies to be applied. Utilises knowledge of immunology to describe current processes e.g. vaccinations for disease prevention and eradication and use of biologics as novel therapeutic targets. Demonstrates effective antimicrobial stewardship through knowledge of antibiotic design and biological usage.
## Domain 3: Pharmacist as a Leader and Manager

<table>
<thead>
<tr>
<th>3.1</th>
<th>Outcome:</th>
<th>Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actively involves patients, carers, the public and other healthcare professionals when evaluating, enhancing and delivering services.</td>
<td>Outcome Level:</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Understands the importance of enabling the voice of patients to be heard and is able to demonstrate ways in which to do this. Demonstrates an ability to effectively engage patients, carers, the public and other health care professionals when evaluating or changing current services or working to introduce a new service.

<table>
<thead>
<tr>
<th>3.2</th>
<th>Outcome:</th>
<th>Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates good organisational skills to deliver tasks to a professional standard.</td>
<td>Outcome Level:</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Routinely plans, prioritises and delivers tasks within agreed timeframes. Utilises strategies to balance conflicting priorities and manage time effectively. Delivers work to a high quality standard.

<table>
<thead>
<tr>
<th>3.3</th>
<th>Outcome:</th>
<th>Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates effective team working and management skills to ensure the quality of service and patient care.</td>
<td>Outcome Level:</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Operates effectively within multi-disciplinary teams recognising the unique skills and knowledge each brings to patient care. Leads, chairs and works within teams effectively. Assumes responsibility and is accountable for contribution to team. Understands the importance of delegation and is able to demonstrate the ability to delegate tasks appropriately and effectively.

<table>
<thead>
<tr>
<th>3.4</th>
<th>Outcome:</th>
<th>Shows how</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devises and utilises effective strategies to lead and implement change.</td>
<td>Outcome Level:</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

**Expectations:**
Understands the basic process of change management. Utilises this knowledge in practice to drive quality improvement. Shows an understanding of how to lead change at local levels.

<table>
<thead>
<tr>
<th>3.5</th>
<th>Outcome:</th>
<th>Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicates and works effectively with other health and social care professionals.</td>
<td>Outcome Level:</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Works collaboratively, professionally and constructively with other health and social care professionals. Recognises individual roles within the health and social care team and utilises these to maximise patient care. Learns from other professionals and applies this to practice. Communicates with other health and social care professionals in a manner which instils confidence and respect. Effectively challenges decisions, pre-empts potential conflict and manages it when it occurs.
Domain 3: Pharmacist as a Leader and Manager

3.6
Outcome: Responds with flexibility and adaptability to new situations and change.

Outcome Level: Does

Expectations: Keeps up to date with developments within the profession and wider healthcare landscape, adapting practice where necessary. Can identify and use appropriate processes to manage change. Is able to move between different working environments without quality of service provision falling. Remains calm and composed when faced with new situations or environments, and responds with flexibility and adaptability. Is able to adapt to differences in practice between the different countries of Great Britain.

3.7
Outcome: Practises within the context of current health-related policy.

Outcome Level: Shows how

Expectations: Is aware of government agendas for health and social care and understands how the health and social services are structured to implement policy. Is able to review current service provision in light of current policy and agendas and make recommendations for change. Keeps up to date with developments within the profession and wider healthcare landscape, adapting practice where necessary.

3.8
Outcome: Engages effectively with local and national strategies to improve public health.

Outcome Level: Does

Expectations: Is aware of current local and national public health policies and demonstrates an ability to work within them. Demonstrates the ability to provide input in to local and national public health policies with a view to enhancing service delivery.

3.9
Outcome: Accesses & critically evaluates national guidance and clinical evidence to support safe, rational & cost effective use of medicines and devices.

Outcome Level: Does

Expectations: Effectively uses national guidance (e.g. Nice, Sign) and evidence from systematic reviews (e.g. Cochrane) to review prescribing practice and make safe therapy recommendations. Uses knowledge of pharmacoeconomics to identify medicines which are likely to be cost-effective in accordance with national expectations. Makes recommendations which demonstrate an efficient use of resources.
## Domain 3: Pharmacist as a Leader and Manager

<table>
<thead>
<tr>
<th><strong>3.10</strong></th>
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<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td>Plans, implements and maintains clinical and medicines governance strategies to assure care and safety.</td>
</tr>
<tr>
<td><strong>Outcome Level:</strong></td>
<td>Shows how</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Demonstrates an ability to develop and apply clinical and medicines governance strategies to the delivery of services. Implements and maintains quality management systems to assure care and safety. Understands the process of quality management, identifies when actions are undertaken for such purposes and works effectively within local systems.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>3.11</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td>Procures, stores, distributes and disposes of medicines and other pharmaceutical products safely, legally and effectively.</td>
</tr>
<tr>
<td><strong>Outcome Level:</strong></td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Demonstrates safe and appropriate purchasing strategies. Stores medicines appropriately and describes actions to be taken when storage requirements are not met. Supplies, distributes and disposes of medicines safely following standard operating procedures and working within legal frameworks. Adapts practice accordingly when supplying medicines from an on-line pharmacy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3.12</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td>Manages and utilises resources in order to ensure efficient work flow and minimise risk in the workplace.</td>
</tr>
<tr>
<td><strong>Outcome Level:</strong></td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Is able to identify the most appropriate use of skill mix to ensure that workflow is efficient and risk is minimised. Demonstrates an ability to respond to changes in work pressures in a safe manner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3.13</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td>Demonstrates an ability to manage resources effectively and participates in financial planning processes.</td>
</tr>
<tr>
<td><strong>Outcome Level:</strong></td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Understands and contributes to the process of financial planning and management, and is aware of its importance. Demonstrates an awareness of financial pressures and the budget process.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3.14</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td>Supervises others involved in service delivery while maintaining accountability.</td>
</tr>
<tr>
<td><strong>Outcome Level:</strong></td>
<td>Does</td>
</tr>
<tr>
<td><strong>Expectations:</strong></td>
<td>Delegates tasks effectively to members of team, whilst maintaining patient safety. Can manage a team, is confident in decision making and understands own accountability.</td>
</tr>
</tbody>
</table>
### Domain 3: Pharmacist as a Leader and Manager

#### 3.15

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checks own and others work effectively.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Legally, technically and clinically checks the safety, suitability and supply of medicines by self, or by others within area of responsibility.

#### 3.16

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides pharmaceutical services with appropriate consideration for environmental sustainability.</td>
<td>Shows how</td>
</tr>
</tbody>
</table>

**Expectations:**
Demonstrates knowledge and skills necessary to improve environmental sustainability of health systems. Identifies potential synergies between policies and practice that provide environmental sustainability and those that promote health. Adheres to legal frameworks relating to reducing carbon admissions and waste disposal.
### Domain 4: Pharmacist as a Clinician and Prescriber

#### 4.1

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actively supports patients and their carers in the safe and effective use of their medicines and devices.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Empowers patients by involving them in their care. Identifies appropriate support and enables patients to make informed choice. Supports self management.

#### 4.2

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertakes effective patient centred consultations.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Builds rapport, identifies patient’s beliefs and concerns and listens effectively. Explains possible unexpected outcomes and what to do if plan is not working. Explains when and how to seek help. Summarises and concludes consultations effectively. Instills confidence, utilising appropriate body language. Shows sensitivity for patients’ emotions and concerns. Selects and ensures appropriate environments for consultations. Involves patients in decision making process, respects and supports patient decisions. Communicates a variety of messages in an empathetic manner showing an understanding of how the message may affect the patient.

#### 4.3

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinically evaluates the appropriateness of prescribed medicines and undertakes evidence based actions.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Reviews prescriptions for patient, dose and formulation appropriateness. Utilises knowledge of the pathophysiology of conditions and outcomes of the treatment options to select or recommend most appropriate therapy. Identifies and prevents potentially clinically important interactions. Identifies and implements opportunities for safe generic substitution. Appropriately utilises clinical management plans to improve prescribing.

#### 4.4

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyses prescriptions for validity, safety and clarity and implements strategies to address identified deficiencies.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Ensures that requests for medicine supplies adhere to current legal requirements and have sufficient clarity as to enable accurate interpretation. Identifies and implements most appropriate patient centred approach to rectify problems. Has a holistic view of the treatment plan and the ability to recognise and respond appropriately when a treatment may be legal but unsafe using pharmaceutical and pharmacological principles.
### Domain 4: Pharmacist as a Clinician and Prescriber

**4.5**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectively uses systems to support safe prescribing and medicines supply.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**

Demonstrates an ability to use current technology in the form of both software and hardware to minimise prescribing errors, improve the quality of prescribing and improve the quality of medicines supply. Applies theoretical frameworks to minimise errors and maximise patient safety. Effectively uses paper based systems such as standard operating procedures for the same purposes. Operates safely within clinical management plan.

**4.6**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies patient non-adherence and implements appropriate patient centred interventions.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**

Effectively identifies non-adherence to medication regimens and its underlying causes. Utilises both simple and evidence based strategies to encourage and improve medicines taking. Utilises a holistic approach to assessment and applies health psychology models and techniques to the delivery of adherence based services.

**4.7**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtains effectively and appropriately utilises relevant patient information.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**

Effectively obtains patient medication and related medical history when transferring between care settings, during all consultations and when responding to medicine information queries. Assesses medical records, obtains holistic view of patient needs and makes changes to treatment plans in response to patient preference.

**4.8**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies misuse of medicines and implements effective strategies to address this.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**

Identifies patients who are potentially using prescribed and over the counter medicines inappropriately and implements strategies to address their actions. Supports and provides holistic care to patients being treated for substance misuse. Safely supervises administration of replacement therapy. Monitors health and compliance of patients on treatment regimens for substance misuse and communicates effectively with patient and care team. Provides services to improve health and minimise harm to substance misusers e.g. needle exchange, paraphernalia and contraception provision. Provides appropriate advice for the utilisation of drugs in sport.
### Domain 4: Pharmacist as a Clinician and Prescriber

#### 4.9

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectively promotes healthy lifestyles utilising available resources and evidence based techniques.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Utilises current evidence, technology and appropriate behaviours to effectively promote health either directly through one to one consultations, outreach activities or indirectly through promotion methods. Demonstrates ability to provide commonly delivered services designed to improve public health e.g. smoking cessation, travel health, family planning and sexual health services. Employs best practice with respect to safeguarding of children and vulnerable adults when delivering services. Administers vaccinations safely. Identifies risky health behaviours and takes steps to address these were practicable. Engages with local and national public health initiatives.

#### 4.10

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
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</thead>
<tbody>
<tr>
<td>Identifies, employs and recommends appropriate health screening processes.</td>
<td>Does</td>
</tr>
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</table>

**Expectations:**
Identifies and utilises case screening techniques to identify patients at high risk and proactively promotes service participation. Demonstrates an ability to use screening tools to assess or score risk and responds appropriately.

#### 4.11

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies and employs appropriate diagnostic or physiological testing techniques to inform clinical decision making and optimise prescribing.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Identifies parameters required for monitoring before and during treatment. Ensures monitoring is performed and responds appropriately to results to reduce risk and enhance patient outcomes. Recommends appropriate tests to confirm interactions or adverse drug events. Is able to perform venipuncture to obtain samples for testing. Constructs clinical management plans which include appropriate monitoring for effectiveness and safety.

#### 4.12

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Outcome Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertakes safe and appropriate physical examination and uses clinical skills to inform clinical decision making and therapeutic action.</td>
<td>Does</td>
</tr>
</tbody>
</table>

**Expectations:**
Is able to perform examinations as required, relevant to own practice and within own competence, e.g. blood pressure, pulse and respiratory rate monitoring etc. list not exhaustive. Is able to recognise presentations of minor and major ailments and can refer to an appropriate practitioner when required.
### Domain 4: Pharmacist as a Clinician and Prescriber

<table>
<thead>
<tr>
<th>4.13</th>
<th>Outcome: Recognises adverse drug reactions and interactions and responds appropriately.</th>
<th>Outcome Level: Does</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Expectations:</strong> Is able to recognise symptoms which suggest that a patient is suffering iatrogenic disease and recommends appropriate actions. Identifies drug, drug food and drug disease interactions and recommends appropriate actions. Proactively makes therapeutic recommendations or choices that avoid possible interactions. Is able to predict the presence of an interaction and undertake appropriate strategies to minimise the effect.</td>
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</table>

<table>
<thead>
<tr>
<th>4.14</th>
<th>Outcome: Undertakes effective differential diagnosis, recommends and implements appropriate actions.</th>
<th>Outcome Level: Does</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Expectations:</strong> Is able to effectively differentiate between symptoms to enable safe treatment within the pharmacy or referral to the most appropriate healthcare professional. Is able to differentiate between adverse drug events and changes in clinical status to enable safe prescribing decisions to be made within a clinical management plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.15</th>
<th>Outcome: Accurately performs pharmaceutical calculations to ensure patient safety.</th>
<th>Outcome Level: Does</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Expectations:</strong> Performs pharmaceutical calculations necessary for role. Performs dose and administration calculations to ensure safety. Safely completes formulae and dilution calculations to determine amount of ingredients required in a pharmaceutical preparation. Estimates effective loading and maintenance doses. Safely performs dose conversions when changing drugs and formulations. Makes rationalised adjustments to doses based on professional judgement and using appropriate reference sources. Able to perform calculations underpinning pharmaceutical sciences.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4.16</th>
<th>Outcome: Responds appropriately to medical emergencies, including provision of first aid.</th>
<th>Outcome Level: Shows how</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Expectations:</strong> Recognises appropriate routes of referral in medical emergencies. Recognises the need for professional judgement about administration of medicines in emergency situations. As a minimum students must undertake a six hour first aid training course that complies with the requirements of the Emergency First Aid at Work course in terms of delivery, assessment and trainer to learner ratios. It must also include the treatment of Anaphylaxis and the use of adrenaline auto injectors and automated external defibrillators.</td>
<td></td>
</tr>
</tbody>
</table>

16
Council meeting 12 September 2013

Public business

Chief Executive & Registrar’s report

Purpose
To keep the Council abreast of significant recent meetings and developments.

Recommendation
The Council is asked to note this paper.

1. Recent meetings

1.1 Listed in Appendix 1 is a non-exhaustive selection of significant meetings held during the two months since the last Council meeting.

1.2 Council members are reminded to liaise with the office before accepting external invitations to speak on behalf of the GPhC, in order to minimise overlap and to ensure they have the most up-to-date supporting material.

2. Chair and Council Member appointments

2.1 Interviews for a new Chair were held on 29 July. The Professional Standards Authority (PSA) has completed its scrutiny of our appointment process and has confirmed to the Privy Council that they may have confidence in the process we followed. We are expecting the name of the successful candidate to be announced by mid September following Privy Council approval.

2.2 The deadline for Council Member applications is 5pm on Friday 13 September. Applications can be made through the following website www.gphccouncilmembers.com/.

2.3 The PSA informed us of a few observations which might provide useful learning points. We will have the opportunity to review the appointments process before the next round.
3. **Rebalancing update**

3.1 The Chair and Chief Executive attended the third meeting of the Rebalancing Programme Board on 22 July. The Programme Board office has issued the following update about discussions at that meeting:

- "The Board recognised the further work undertaken since the last meeting to allow members to consider in detail the issue of providing for exemption from criminal sanction for dispensing errors. Discussion focused on this issue and good progress was made towards reaching a general consensus on the overall approach to the proposed exemption (the provisions to be met to trigger its engagement and situations where it would not.)

- Other items on the agenda included consideration of an approach for hospital pharmacy and an initial discussion on the roles of pharmacy owners, superintendents and responsible pharmacists.

- Members agreed it was crucial to enable patients and the public, partners and stakeholders to contribute to this discussion and plans to hold a Partner Forum in early October will now be progressed. The format of that event will be agreed in due course.

- Information about the Board, its terms of reference, membership and minutes of meetings are available at: [https://www.gov.uk/government/policy-advisory-groups/pharmacy-regulation-programme-board](https://www.gov.uk/government/policy-advisory-groups/pharmacy-regulation-programme-board)

- The next meeting of the Board will take place on 10th September."

4. **GPhC Annual Report**

4.1 The GPhC Annual Report 2013 [Annual Report 2013 [PDF 1.13 MB]](Annual Report 2013 [PDF 1.13 MB]) was published on 27 June. The report sets out what we have achieved over the year, including:

- launching new standards for registered pharmacies
- developing a new approach to regulation and inspection for registered pharmacies
- reducing fees for all registrants by 10 per cent and freezing them at 2012/13 levels for 2013/14
- improving the management of investigations and fitness to practise case processes – work that has been recognised in an external evaluation by the Professional Standards Authority

5. **Registration of non-EEA trained applicants**

5.1 The PSA has been commissioned by the Department of Health to review the processes used by the health and social care regulators to register ‘international applicants’ i.e. those trained outside the EEA who hold a non-EEA passport.

5.2 All regulators have been asked for information on their approach to registering international applicants with a view to sharing good practice and highlighting
areas of concern. We are also being asked how we assure the identity, qualifications and competence of international applicants, how many non-EEA trained registrants we have, and how many applications we receive annually, broken down by country.

5.3 Part of this work - producing an overview of regulators’ processes for registering international applicants - has been carried out on behalf of the PSA by the GPhC's International and Registration Policy Manager on a short secondment.

6. Review of NHS Pharmaceutical Care of Patients in the Community in Scotland

6.1 The review of NHS Pharmaceutical Care of Patients in the Community in Scotland by Dr Hamish Wilson and Professor Nick Barber was published on 14 August 2012. The report make specific reference to the GPhC, welcoming the approach we have taken in developing standards for registered pharmacies.

6.2 The report focuses on 'what' should be done to develop NHS pharmaceutical care in the community in Scotland rather than describing the 'how'. Two key themes that run through the report are the importance of professionalism and effective relationships (relationships between individual professionals and the public, relationships between professionals and relationships between organisations) in realising the full benefits of pharmaceutical care. Reference is also made to redefining the relationship between the pharmacy owner and the individual pharmacist to ensure that individuals have the freedom and support to exercise professional judgement.

6.3 The report makes a number of recommendations in relation to workforce planning and education. It makes clear that Scotland cannot work in isolation from developments elsewhere in the UK and Europe, specifically citing Modernising Pharmacy Careers (MPC), and recommends that there should be an early review of all aspects of pharmacy workforce and associated education and training to take forward an integrated approach which meets future needs in Scotland.

6.4 Scottish Government will be using the report to inform development of its vision for pharmaceutical care for the next 10 years. This vision document is expected to be published over the next few weeks and Scottish Government has stated its intention to work in collaboration with stakeholders to take things forward. The full report can be accessed at http://www.scotland.gov.uk/Publications/2013/08/4406


7.1 As agreed at the June Council meeting we are seeking RIPA powers to authorise directed surveillance and the use of covert human intelligence sources in line with recommendations set out in the Office of Surveillance Commissioners' report dated 11 January 2013.
7.2 The GPhC is listed as a relevant authority in RIPA but due to a legislative omission does not have powers to use directed surveillance or authorise the use of covert human intelligence sources.

7.3 We have supplied information to the Department of Health (DH) setting out the powers we are seeking and the problems they will address and will now work with DH to progress this application.

8. **GPhC Registrant Survey**

8.1 The Registrant Survey, being carried out by NatCen Social Research on behalf of the GPhC, was launched on 19 August and will run for six weeks. An invitation to take part in the survey was sent to all 22,000 pharmacy technicians and a large sample of 30,000 pharmacists.

8.2 The anonymised results of the survey will be made public, enabling the GPhC and others to better understand the roles and responsibilities of pharmacists and pharmacy technicians. We hope to report on findings towards the end of 2013.

9. **Public Interest Disclosure Act 1998 (PIDA)**

9.1 The Department of Health and the Department for Business Innovation and Skills are making a joint Order which will update the Public Interest Disclosure (Prescribed Persons) Order 1999.

9.2 The Public Interest Disclosure (Prescribed Amendments) Order 2013 will amend the list of prescribed persons to which a worker may make a protected disclosure in the public interest to include the health and social care professional regulators.

9.3 It is proposed that the changes will come into effect on 1 October 2013.

10. **Pre-registration training surveys**

10.1 The GPhC is launching a series of surveys to gather information about pre-registration training, both for pharmacists and for pharmacy technicians. The surveys will be used to track trends and themes and to inform the GPhC’s education development work in relation to Modernising Pharmacy Careers (MPC) and other education reform programmes. The surveys are being designed by a team led by Professor Alison Blenkinsopp, chair in the practice of pharmacy and director of the Pharmacy Practice Research Group at the University of Bradford. The surveys will be delivered online by Information by Design (IbyD), a leading provider of market research and customer satisfaction research. The surveys will be anonymous and will cover the whole of GB. The results of the surveys will be made public.

10.2 The surveys will run from 2013-2015 in the first instance and will be introduced in a staggered way. In November 2013, a survey of pre-registration trainee pharmacists will be introduced and will continue until 2015. In 2014 the survey will be joined by two others - a survey of pharmacist pre-registration tutors and pre-registration pharmacy technicians. Everyone in the survey will be sent a
personal email inviting them to take part and the surveys will be able to be completed online.

11. **Survey of pharmacy technician education and training**

11.1 The GPhC has commissioned a major study into the initial education and training of pharmacy technicians. The study will gather data on the experiences of pharmacy technician trainees studying at further education colleges, studying at a distance, studying in community settings and studying in the NHS. As well as surveying trainees, the study will engage with course providers, awarding bodies and employers. This will be the first systematic study of this sector and will inform the GPhC’s education development work around the quality assurance of pharmacy technician education.

11.2 The study will be led by Dr Ellen Schafheutle, senior lecturer in law and professionalism in pharmacy and a researcher in the Centre for Pharmacy Workforce Studies at the Manchester Pharmacy School, University of Manchester. It will begin in Autumn 2013 and the report, which will be made public, will be published mid 2014.


12.1 Prompted by publication of reports by Which? highlighting the variable advice provided to patients the GPhC and the RPS held a workshop on 8 July with almost 100 participants which included the author of the reports plus representatives from pharmacy organisations, training providers, medicine manufacturers, pharmacists, pharmacy technicians, trade bodies and patients.

12.2 Participants at the event agreed that:

- The quality of advice about medicines provided in community pharmacies is variable.
- Action needs to be taken by everyone in the sector to address this variability
- Delegates would carry out a workshop in their own organisation within the next 6 months to identify what actions they could take to improve the quality of advice.

12.3 Key themes identified from the event will be used by participants to refine their own organisation’s objectives. These include:

- Redefining best practice and looking at what “great care and advice” looks like in community pharmacy
- Identifying how the whole pharmacy team within a community pharmacy can be given time and space to develop their knowledge and skills
- Looking at the role of the medicine counter assistant within a pharmacist-led team to ensure people get advice from the right person at the right time
Improving the recognition of excellent advice about medicines from pharmacy within the profession and promoting this to patients and the public.

13. Professional Standards Authority request for information on duty of candour

13.1 The PSA has been asked by the Department of Health to provide advice on how professional regulation can encourage healthcare workers to be more candid when care goes wrong. This request has arisen in response to recommendations about the principles of candour, openness and transparency contained in the Francis report.

13.2 To help with this all health and social care regulators have been asked to provide information about their standards and guidance, declarations required of registrants on registration/renewal and as much information as possible about the frequency and outcomes of fitness to practise cases involving concerns/allegations of candour failure. We have provided the PSA with our response to their queries.

14. Consultations

14.1 A list of active consultations with which the organisation is or is not engaging is included at Appendix 2.

Recommendation

The Council is asked to note this paper.

Duncan Rudkin, Chief Executive & Registrar

General Pharmaceutical Council
duncan.rudkin@pharmacyregulation.org, tel 020 3365 3501

21 August 2013
Appendix 1

List of Meetings

Listed below is a non-exhaustive selection of significant meetings held during the two months since the last Council meeting. Initials are as follows: Bob Nicholls (RMN), Duncan Rudkin (DR), Bernard Kelly (BK), Hugh Simpson (HS), Lyn Wibberley (LW), Claire Bryce-Smith (CBS):

Chair:
- Health Education England National Directors of Education & Quality meeting - speaking
- Pharmacy and Public Health Forum meeting
- Royal Pharmaceutical Society (RPS) Pharmaceutical Care Awards
- King’s Fund Lecture – Clayton Christensen on encouraging innovation
- Director of Policy, Nuffield Trust – Meeting regarding RPS Commission on future models of care
- Chief Pharmaceutical Officer, NHS England– update meeting
- Nuffield Trust event - NHS @ 65: rejuvenate or retire?
- GPhC & RPS Event - Responding to the Which? Report: The way forward for pharmacy (with DR)
- Chair, Chief Executive & Director of Education & Quality, Health Education England – introductory meeting (with DR)
- Stephen Dorrell MP – update meeting (with DR)
- President, Vice President & Education Officer, Association of Pharmacy Technicians UK (APTUK) – update meeting (with DR)
- Department of Health (DH) Rebalancing Programme Board (with DR)
- Modernising Pharmacy Careers (MPC) Board meeting

Staff:
- Chair and Chief Executive, Community Pharmacy Wales – update meeting (DR)
- Chief Pharmaceutical Officer, Welsh Government – update meeting (DR)
- Chief Executive, Healthcare Inspectorate Wales – introductory meeting (DR)
- Chair, RPS Welsh Pharmacy Board – update meeting (DR)
- Health & Care Professions Council (HCPC) event - Research in health and social care regulation: What is the added value? (DR)
- Pennington’s Solicitors Seminar – Reflections on the Mid-Staffordshire report and Diversity Monitoring (DR)
- Directors of Pharmacy Scotland meeting – update on inspection (CBS)
- DH stakeholder event - Patients first and foremost (DR)
• Chief Executive, Professional Standard Authority – update meeting (DR)
• Chief Executive & Registrar, General Medical Council – update meeting (DR with HS)
• GPhC & RPS Event - Responding to the Which? Report: The way forward for pharmacy (DR with RMN)
• Chair, Chief Executive & Director of Education & Quality, Health Education England – introductory meeting (DR with RMN)
• Chief Pharmaceutical Officer, Scottish Government – update meeting (HS)
• Chief Executive, Community Pharmacy Scotland – update meeting (HS)
• Group Quality Systems Director/Chief Pharmacist, Nuffield Health – Visit to Nuffield Health hospital and meeting with other staff (DR)
• Stephen Dorrell MP – update meeting (DR with RMN)
• President, Vice President & Education Officer, Association of Pharmacy Technicians UK (APTUK) – update meeting (DR, RMN, LW)
• Department of Health (DH) Rebalancing Programme Board (DR with RMN)
• President & Vice President, British Pharmaceutical Students Association – update meeting (DR)
• Health and Social Care Regulators’ Forum (DR)
• Deputy Director, Francis Implementation Team, DH, Chief Executive & Registrar, General Optical Council, Chief Executive & Registrar, General Dental Council – update meeting (DR)
• Head of Regulation, General Osteopathic Council (CBS)
• Regulators Directors of Resources meeting (BK)
• Chief Executive, The Patients Association – update meeting (DR)
• Associate Director, London and East Institutional Team, Higher Education Funding Council for England (HEFCE) - update meeting (HS)
• Chief Pharmaceutical Officer, NHS England – update meeting (DR)
• FIP World Congress of Pharmacy & Pharmaceutical Sciences – speaking (DR)
• Delegation of the Health, Labour & Welfare Committee from the House of Representatives of the Parliament of Japan (DR)
• Bob Russell MP – update meeting (HS)
• President and Chief Executive, Australian Pharmacy Council – update meeting (DR)
### Active and new consultations

<table>
<thead>
<tr>
<th>Title</th>
<th>By</th>
<th>Summary</th>
<th>Deadline</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation on changes to the way we inspect, regulate and monitor care services</td>
<td>CQC</td>
<td>This consultation is an important step towards making the changes needed to deliver the CQC’s purpose. To ensure sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to make improvements. <a href="http://www.cqc.org.uk/public/sharing-your-experience/consultations/consultation-changes-way-we-inspect-regulate-and-monitor">http://www.cqc.org.uk/public/sharing-your-experience/consultations/consultation-changes-way-we-inspect-regulate-and-monitor</a></td>
<td>12/08/13</td>
<td>Responding: Hugh Simpson/Claire Bryce-Smith</td>
</tr>
<tr>
<td>Consultation on strengthening corporate accountability in health and social care</td>
<td>DH</td>
<td>The consultation document sets out proposals to introduce a new registration requirement covering the fitness of directors of boards and to improve the way that existing sanctions are used to prosecute providers for failings in the quality and safety of care. The consultation will inform the new draft regulations which will be set out by the Department in the autumn and which we propose to lay before Parliament at the end of 2013. <a href="https://www.gov.uk/government/consultations/improving-corporate-accountability-in-health-and-social-care">https://www.gov.uk/government/consultations/improving-corporate-accountability-in-health-and-social-care</a></td>
<td>06/09/13</td>
<td>Responding: Jerome Mallon/Paul Fredericks</td>
</tr>
<tr>
<td>Title</td>
<td>By</td>
<td>Summary</td>
<td>Deadline</td>
<td>Response</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Five year rule guidance consultation</td>
<td>NMC</td>
<td>Consultation on the introduction of guidance to cover individuals who apply to register qualifications awarded more than five years previously. The NMC’s legislation, the Nursing and Midwifery Order 2001 (the Order) currently allows UK trained nurses and midwives who hold approved qualifications to enter the register for a period of up to five years following completion of that qualification. <a href="http://www.nmc-uk.org/Get-involved/Consultations/Five-year-rule-guidance-consultation/">http://www.nmc-uk.org/Get-involved/Consultations/Five-year-rule-guidance-consultation/</a></td>
<td>09/10/13</td>
<td>Reviewed by Joanne Martin: Decision not to respond.</td>
</tr>
<tr>
<td>Scottish Parliament Health and Sports Committee Call for Evidence</td>
<td>Scottish Parliament</td>
<td>Legislation that sets out proposals to ensure that Scotland’s health and social care systems work together effectively to improve the provision of care in our communities will be scrutinised by the Health and Sport Committee. MSPs have issued a call for views on the proposals.</td>
<td>02/08/13</td>
<td>Reviewed by Lynsey Cleland: Decision not to respond</td>
</tr>
<tr>
<td>Guidance on reporting criminal proceedings and the use of social networking sites</td>
<td>GDC</td>
<td>GDC are seeking views on two new pieces of guidance; Reporting on Criminal Proceedings and The use of Social Networking Sites.</td>
<td>25/06/13</td>
<td>Reviewed by Standards Advisory Team and Martha Pawluczyk. Decision not to respond</td>
</tr>
<tr>
<td>Title</td>
<td>By</td>
<td>Summary</td>
<td>Deadline</td>
<td>Response</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cross border Consultation</td>
<td>MHRA</td>
<td>Informal consultation on the MHRA's intention to amend medicines legislation to implement changes arising from the adoption of Article 11 of the Cross-Border Healthcare Directive EU Directive 2011/24 EU on the application of patients' rights in cross-border healthcare.</td>
<td>17/06/13</td>
<td>Responded. Martha Pawluczyk / Ambrose Paschalides. Please see response <a href="#">here</a>.</td>
</tr>
<tr>
<td>Commission on Future Models of Care</td>
<td>RPS</td>
<td>Commission on Future Models of Care is looking at models of care delivery that involve pharmacy. The Commission is keen to identify and understand innovative examples of good practice in pharmacy care, and to determine how such examples could become more widespread in the NHS. <a href="http://www.rpharms.com/leading-on-nhs-reforms-for-pharmacy/models-of-care.asp">http://www.rpharms.com/leading-on-nhs-reforms-for-pharmacy/models-of-care.asp</a></td>
<td>Deadline has been revised.</td>
<td>Responding: Hugh Simpson. Ongoing.</td>
</tr>
</tbody>
</table>
Public business

Remuneration of Investigating Committee Chairs and Deputy Chairs

Purpose
This paper contains recommendations for Council arising from the Remuneration Committee’s recent review of the remuneration rates of the legally qualified chairs and deputy chairs of the Investigating Committee.

Recommendation
The Council is asked to agree the following recommendations from the Remuneration Committee:

i. That the fee for Investigating Committee chairs and Deputy chairs should be increased by £6 from £330 to £336.

ii. The effective date for the increase should be 1 June 2013

1. Background

1.1 At the meeting in June, Council approved recommendations from the Remuneration Committee, regarding the remuneration of a number of the associate groups; including the legally qualified chairs and deputy chairs of the Fitness to Practice Committee (FiPC) and the Registration Appeals Committee (RAC).

1.2 The daily attendance fees of the Investigating Committee (IC) legally qualified chair and the two IC legally qualified deputy chairs differs from those of legally qualified chairs and deputy chairs of the FiPC and RAC - see appendix 1. Due to an office oversight, Remuneration Committee did not look at IC chair/deputy fees separately when it considered associate fees in April, and was therefore not able to make any recommendations to Council. Council is therefore asked to
Remuneration of IC Chairs and Deputy Chairs

Council 12 September 2013

separately approve Remunerations Committee’s recommendations regarding IC legally qualified chair and deputy chairs fees now.

1.3 The IC legally qualified chairs and deputy chairs currently receive a daily fee of £330. The role performed by IC Chair and Deputy Chair differs from that of legally qualified chairs and deputy chairs of FtP and RAC.

1.4 Benchmarking has confirmed that the legally qualified IC chair and deputies currently receive a fee which is not dissimilar to that received by chairs in other regulators.

2. Options and recommendations

1.5 The Remuneration Committee considered various options before making their recommendations to Council, which included: making no change and mirroring the increase in fees by the same amount agreed for legally qualified chairs and deputies of the FtPC and RAC i.e. £6. The Committee also noted the Office’s intention to generally review the Remuneration Policy for Associate Groups for consideration at its April 2014 meeting.

Recommendation

The Council is asked to agree the following recommendations from the Remuneration Committee:

i. That the fee for Investigating Committee chairs and Deputy chairs should be increased by £6 from £330 to £336.

ii. That the effective date for the increase should be 1 June 2013

Fola Tayo, Associates Manager
fola.tayo@pharmacyregulation.org
Tel 020 3365 3504

6 August 2013
Appendix 1

**GPhC daily fees**

<table>
<thead>
<tr>
<th>Statutory Committee Role</th>
<th>Daily fee before 2013 review</th>
<th>Daily fee after 2013 review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legally qualified chair of FtPC or RAC</td>
<td>£583</td>
<td>£589</td>
</tr>
<tr>
<td>Legally qualified deputy chair of FtPC and RAC</td>
<td>£468</td>
<td>£486</td>
</tr>
<tr>
<td>Chair and deputy chair of IC</td>
<td>£330</td>
<td>tbc</td>
</tr>
<tr>
<td>Members</td>
<td>£223</td>
<td>£300</td>
</tr>
</tbody>
</table>

Appendix 2

**Benchmarking Data March 2013**

<table>
<thead>
<tr>
<th>Regulatory Body</th>
<th>Daily Attendance Fee for Committee Chairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Chiropractic Council</td>
<td>£300</td>
</tr>
<tr>
<td>General Dental Council</td>
<td>£353</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery Council</td>
<td>£340</td>
</tr>
<tr>
<td></td>
<td>£170 part day for hearings finishing before 1.00pm</td>
</tr>
<tr>
<td>Medical Practitioners Tribunal Service</td>
<td>£340</td>
</tr>
<tr>
<td>General Osteopathic Council</td>
<td>£306</td>
</tr>
<tr>
<td>Health &amp; Care Professions Council</td>
<td>£310</td>
</tr>
</tbody>
</table>

NB: The other healthcare regulatory bodies do not have deputy chairs
Council meeting date 09.13/C/11

Public business

Council and Committee meeting schedule 2014

Purpose
To agree the Council, Audit and Risk Committee and Remuneration Committee meeting dates 2014.

Recommendations
The Council is asked to agree the schedule of 2014 Council, Audit and Risk Committee and Remuneration Committee meeting dates at Appendix 1.

1. Introduction
1.1 Dates for Council, Audit and Risk Committee and Remuneration Committee meetings have been agreed up to the end of 2013. It is good business planning to set dates for 2014 now so that Council and Committee members can plan their diaries accordingly.

1.2 The dates in the proposed schedule at Appendix 1 are based on those circulated to members in July 2013, adjusted as required.

1.3 A paper setting out the business cycle will be presented to Council in November.

2. Key considerations
2.1 A number of minor changes have been made to the draft list of Council dates was passed to members in July.

2.2 The February Council meeting, originally scheduled for 13 February, has been moved to 6 February. This reduces the length of time following the November Council meeting while still allowing time for business such as the fees consultation and the budget to be prepared.

2.3 A workshop on 11 June has been added. This was omitted from the original list.
2.4  The Committee dates have been checked with the external members of those Committees. The dates chosen avoid all public holidays and major religious festivals. We are not planning to hold any meetings outside of London in 2014.

2.5  The proposed dates have been discussed informally with the recommended candidate for Chair of Council. Should any changes be required, Council members will be advised as soon as possible.

3.  **Equality and diversity implications**

3.1  We have proposed dates that avoid major religious festivals. There are no other equality and diversity implications arising out of this paper.

4.  **Communications implications**

4.1  Meeting dates for 2014 will be communicated to the press at an opportune time. There are no other communications implications arising out of this paper.

5.  **Resource implications**

5.1  Holding all Council meetings in London will reduce costs without materially affecting the GPhC’s relationship with its stakeholders. There are no other resource implications arising out of this paper.

6.  **Risk implications**

6.1  Fixing a schedule of 2014 meeting dates now reduces the risks of the GPhC not meeting its objectives. There are no other risk implications arising out of this paper.

**Recommendations**

The Council is asked to agree the schedule of 2014 Council, Audit and Risk Committee and Remuneration Committee meeting dates at Appendix 1.

Paula Woodward, Council Secretary

*General Pharmaceutical Council*

paula.woodward@pharmacyregulation.org

Tel 020 3365 3522

29 August 2013
### 2014 Council and Committee meeting dates

Five Council meetings and six Council workshops have been planned for next year. They normally take place on the second Thursday of each month, with no meetings in January or August.

The exceptions are the February meeting which takes place in the first week of the month to reduce the length of time between meetings, and the June workshop which gives the Council an opportunity to have an in-depth workshop alongside a Council meeting.

The dates for the workshops are booked in advance but will only be used if necessary. Please keep them free until you know otherwise.

<table>
<thead>
<tr>
<th>Month</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>No meetings</td>
</tr>
<tr>
<td>February</td>
<td>[Wednesday 5 February – induction for new CMs only]</td>
</tr>
<tr>
<td></td>
<td>Thursday 6 February - Council Meeting [and opportunity to meet new CMs]</td>
</tr>
<tr>
<td></td>
<td>Tuesday 25 February – Audit and Risk Committee</td>
</tr>
<tr>
<td></td>
<td>Thursday 27 February – Remuneration Committee</td>
</tr>
<tr>
<td>March</td>
<td>Thursday 13 March – Keep free for Council Workshop</td>
</tr>
<tr>
<td>April</td>
<td>Thursday 10 April – Council Meeting</td>
</tr>
<tr>
<td></td>
<td>Thursday 24 April - Remuneration Committee</td>
</tr>
<tr>
<td>May</td>
<td>Thursday 8 May – Keep free for Council Workshop</td>
</tr>
<tr>
<td></td>
<td>Wednesday 28 May – Audit and Risk Committee</td>
</tr>
<tr>
<td>June</td>
<td>Wednesday 11 June – Keep free for Council Workshop</td>
</tr>
<tr>
<td></td>
<td>Thursday 12 June – Council Meeting</td>
</tr>
<tr>
<td>July</td>
<td>Thursday 10 July – Keep free for Council Workshop</td>
</tr>
<tr>
<td>August</td>
<td>no meetings</td>
</tr>
<tr>
<td>September</td>
<td>Thursday 11 September – Council Meeting</td>
</tr>
<tr>
<td>October</td>
<td>Thursday 9 October – Keep free for Council Workshop</td>
</tr>
<tr>
<td></td>
<td>Wednesday15 October – Audit and Risk Committee</td>
</tr>
<tr>
<td></td>
<td>Thursday 25 October – Remuneration Committee</td>
</tr>
<tr>
<td>November</td>
<td>Thursday 13 November – Council Meeting</td>
</tr>
<tr>
<td>December</td>
<td>Thursday 11 December – Keep free for Council Workshop</td>
</tr>
</tbody>
</table>

29 August 2013
Public business

Direct Debit Scheme indemnity provided to National Westminster Bank

Recommendation

The Council is asked to agree:

i. The replacement of the existing personal indemnities given by five members of Council, by a body corporate indemnity given by GPhC.

ii. The application of GPhC’s seal to the new deed of indemnity.

1. Background

1.1 The GPhC collects a very substantial number of renewal fees from registrants through established direct debit arrangements. This allows the GPhC to deduct money from registrants’ bank accounts on an ongoing basis once a direct debit mandate has been established. This is a very considerable privilege and is based upon an absolute guarantee given by the registrant’s bank that the privilege will not be abused and should it be, then the bank will guarantee to reimburse the individual without argument. In return for this privilege the bank demands that we in turn provide an indemnity to them that matches their indemnity to the individual.

1.2 When the GPhC started we needed to establish direct debit arrangements with our bankers. As a new organisation with an unusual status not familiar to the bank we were interpreted by the banks as an unincorporated body. The bank therefore demanded that we provide personal indemnities from 5 members of Council. Out of necessity this arrangement was agreed to and the indemnities put in place, the individual council members who agreed to sign the indemnity arrangements were in turn indemnified by the GPhC.

1.3 Prompted by questions raised by the new chair of the audit and risk committee as to why such an arrangement existed we have spoken to our bank and challenged them to relook at our status.

1.4 Having been established for some time and with some credible financial history and resources the bank has been more willing to look again at our status and
has agreed that we do have body corporate status established by statute. As such they have agreed to accept a corporate indemnity from us in substitute for the personal indemnities previously given.

2. **Action Needed**

2.1 For the council to agree the provision of a corporate indemnity to National Westminster bank and for the GPhC seal to be applied to the indemnity. The signature of two Council members will need to be applied to the indemnity on behalf of the GPhC as a body corporate. A copy of the indemnity can be found at appendix 1.

3. **Equality and diversity implications**

3.1 None

4. **Communications implications**

4.1 To inform existing and future Council members of the changed arrangements.

4.2 To inform external auditors of the changed arrangements

5. **Resource implications**

5.1 None

6. **Risk implications**

6.1 In practice, under the original deed of indemnity, any claims would have been met by GPhC and not by the individual members. Under the new deed of indemnity any claims will still be met by GPhC

6.2 The five Council members will be free of any personal liability.

**Recommendation**

The Council is asked to agree:

i. The replacement of the existing personal indemnities given by five members of Council, by a body corporate indemnity given by GPhC.

ii. The application of GPhC’s seal to the new deed of indemnity.

Bernard Kelly
Director of Resources and Customer Services
Bernard.Kelly@pharmacyregulation.org
Tel: 020 3365 3510

28 August 2013
STANDARD INDEMNITY

To each credit institution which, from time to time, holds an allocation of UK sorting code numbers and against whose customers’ accounts we may make direct debit payment requests ("Direct Debits").

1. In consideration of your each accepting instructions from time to time from us, or from our agent or anyone purporting to be our agent, to debit yourselves or the account of your customers with the amounts specified in such instructions.

WE UNDERTAKE TO INDEMNIFY each of you, on your first demand, against any claim made against you as a result, directly or indirectly, of your acting or failing to act on any such instruction.

2. The claims referred to in paragraph 1 above include legal actions, and references to any ombudsman or similar scheme, as well as demands made directly to you. We agree that any of you may accept, reject or compromise any claim without consulting us and without thereby reducing our liability under this indemnity.

3. We acknowledge that the operation of the Direct Debit Scheme as a high volume system does not always allow the checking of every debit against instructions held, and agree that this Indemnity shall apply whether or not any such check has been made, and whether or not any instruction has been received from your customer and remains in force.

4. We similarly agree that you are under no obligation to enquire whether or not any condition or purpose of payment specified in any instruction has been complied with.

5. We agree at all times to comply with the rules of the Direct Debit Scheme as set out in the Service User’s Guide and Rules to the Direct Debit Scheme, as amended from time to time.

6. We shall make payment under this Indemnity on your first demand and without proof of loss within 14 working days of the date of a properly completed claim from you.

6.1 Having paid a claim under this Indemnity, we retain the right to make a repayment claim against you to the extent that any loss was caused by your or your agents’ failure to comply with the requirements of the Direct Debit Scheme set out in the Service User’s Guide and Rules to the Direct Debit Scheme (the Guide) as amended from time to time, and in accordance with the procedures set out in the Guide. (In the Guide, such a repayment claim is called a “Counter Claim”.)

6.2 Any repayment claim shall be made following the procedures set out in the Guide within 14 working days of payment of the claim.

6.3 Following resolution of the repayment claim any sum due to us will be paid within 90 days.

7. This Indemnity is given in addition to any other indemnity already given either by us or by any other person in support of our participation in the Direct Debit Scheme. Should there be a direct conflict between any of the terms of this Indemnity and any earlier one, the term of this Indemnity shall prevail.

8. This Indemnity shall continue to apply notwithstanding any payment made by us, any account stated, or any compromise, waiver, or indulgence made by either you or us in respect of any claim or repayment claim.

9. This Indemnity shall not be affected by any change in name of any of you, or of us, or of any change in the legal status of any of you including any change brought about by merger or amalgamation, in which case it shall apply for the benefit of the merged company, or any successor company.

10. We may terminate this Indemnity at any time by giving notice to our sponsoring bank and to each other credit institution who has accepted the cover it provides, but shall remain liable in respect of any debits that have been originated before such notice is received by each institution.

11. This Indemnity shall be governed by, and interpreted in accordance with, the laws of England.

12. Any legal proceedings against us arising out of this Indemnity may be commenced, at your choice, in either the courts of England (to which we irrevocably and unconditionally submit) or the courts of the country in which we are incorporated or the courts of any country in which we carry on business.

13. We shall promptly inform you of any change in our name or in our legal status, including any change arising by virtue of the operation of the Insolvency Acts 1986 or any other insolvency or similar legislation in the United Kingdom or elsewhere which applies to us, and including any change effected for the purpose of reorganisation.

14. Should we at any time become, or discover we are, legally incapable of giving effect to this Indemnity (either as a whole or partially) we shall notify you forthwith and shall cease to originate Direct Debits, and shall take such other reasonable steps as you may require in order to protect the interests of your customers and the integrity of the Direct Debit Scheme. If as a result of incapacity we are only partially disabled from giving effect to this Indemnity we shall continue to fulfil all our other obligations under it.

15. Any notice required to be given to us in connection with this Indemnity or any claim may (in addition to any other place at which they may properly be served) be delivered to us at our registered office, or at any address at which we carry on business or at the address given below, or at such other address as may be given by us to Bacs Payment Schemes Limited for this purpose.

EXECUTED AS A DEED by __________________________ __________________________ plc / Limited

(Company registration number __________________________)

this __________________________ day of __________________________ 20 __________________________

(Name in capitals) (Signature of person signing)

Director

(Name in capitals) (Signature of person signing)

Director/Secretary/Witness

*Address of Witness: ________________________________________________________________