Meeting of the Council

11 September 2014
11:30am to 15:30pm
Council Room, 25 Canada Square, London E14 5LQ

Agenda

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Public business

1. Attendance and introductory remarks
   Presenter: Nigel Clarke

2. Declarations of interest
   Presenter: All

3. Minutes of last meeting
   Public session 12 June 2014
   Presenter: Nigel Clarke

4. Actions and matters arising
   Presenter: Nigel Clarke

5. Strategic Plan 2015-18
   For decision
   Presenter: Duncan Rudkin

6. Performance Monitoring Report
   For discussion
   Presenter: Duncan Rudkin

7. Reporting on the June 2014 Registration Assessment
   For discussion
   Presenter: Damian Day

8. Council working groups
   a. Council Appointments Working Group Progress Report
      For decision
      Presenter: Judy Worthington

   b. Developing the draft continuing fitness to practise framework
      For decision
      Presenter: Osama Ammar

   c. Establishment of Pharmacy Regulation Development Assurance Group
      For decision
      Presenter: Duncan Rudkin
   For discussion
   14.09.C.05
   Duncan Rudkin

10. Chief Executive & Registrar’s report
    For noting
    14.09.C.06
    Duncan Rudkin

11. Audit and Risk Committee minutes, 24 July 2014
    For noting
    14.09.C.07
    David Prince

12. Policy and Procedure Reviews
    For decision
    14.09.C.08
    Matthew Hayday

13. Any other public business
    Nigel Clarke

Confidential business

14. Declarations of interest
    All

15. Minutes of last meeting
    Confidential session 12 June 2014
    14.09.C.09
    Nigel Clarke

16. Actions and matters arising
    Nigel Clarke

17. Audit and Risk Committee minutes
    For noting
    14.09/C/10
    David Prince

18. Strategic Risk update
    For noting
    14.09/C/09
    Matthew Hayday

19. Any other confidential business

Date of next meeting
13 November 2014
Minutes of the **Council** meeting held on **12 June 2014** at
129 Lambeth Road, London, at 10:30am

**Present**

Nigel Clarke – Chair  
Alan Kershaw (from minute 12)  
Berwyn Owen  
David Prince  
Digby Emson  
Evelyn McPhail  
Judy Worthington  
Liz Kay  
Mary Elford  
Mohammed Hussain  
Samantha Quaye  
Sarah Brown  
Soraya Dhillon  
Tina Funnell

**Apologies**

Gary Richardson (Interim Director of Knowledge & Insight)

**In attendance**

Duncan Rudkin (Chief Executive and Registrar)  
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)  
Damian Day (Head of Education and Registration Policy)  
Lyn Wibberley (Head of Executive Office)  
Matthew Hayday (Head of Governance)  
Paula Woodward (Council Secretary)

**Public business**

22. **ATTENDANCE AND INTRODUCTORY REMARKS**

22.1. The Chair welcomed all to the meeting.

22.2. Alan Kershaw sent his apologies for the first part of the meeting (to minute 12). There were no further apologies.

23. **DECLARATIONS OF INTEREST**

23.1. The following interests were declared.

23.2. *Item 7: Chief Executive and Registrar’s report*
Sam Quaye, in relation to the technicians’ survey.
23.3. Item 8: Performance of ‘Black - African’ candidates and item 9: Revising initial education and training standards for registrants
Soraya Dhillon, Liz Kay, Mary Elford and Digby Emson declared interests because of their roles in training and education.

23.4. Item 15: Appointment of external auditors
David Prince and Matthew Hayday declared interests because they had worked with Grant Thornton previously.

23.5. Item 16: Standing orders and scheme of delegation
The members of the audit and risk committee and the remuneration committee declared interests.

24. MINUTES OF THE PUBLIC SESSION OF THE PREVIOUS MEETING
24.1. The minutes of the public session of the meeting held on 10 April 2014 were agreed as a true record subject to the addition of a reference to genomics in minute 8.4.

25. MATTERS ARISING AND ACTIONS
25.1. There were no matters arising.
25.2. All actions set out in the minutes were completed or were covered by items on the agenda.

26. CORPORATE PLAN 2014-15: PERFORMANCE MONITORING (ITEM 5) AND PERFORMANCE MONITORING REPORT (ITEM 6)
26.1. The Council agreed that these two items should be taken together.
26.2. Duncan Rudkin informed members that, in future, the two reports would be integrated and updated to present the Council with trends and insight into the organisation’s work, making use of the increasing knowledge and information management capacity.
26.3. Damian Day (DD) reminded members that the corporate plan report only covered the first three months of implementation of the plan and that the second edition would be able to show progress more clearly.
26.4. In response to members’ questions relating to inspections, Claire Bryce Smith (CBS) reported that the number of inspections being carried out was improving as the systems used in the new inspection model became more normalised, with those pharmacies longest overdue an inspection being dealt with first. CBS also summarised the work being undertaken to build capacity and improve performance in the management of fitness to practise cases. The Council noted that it was difficult to provide a brief summary of such a complex areas of work in this report.
26.5. The Council noted that the corporate plan covered only one year of the strategic plan and that some areas of work were in the early stages of
development, while others would not begin until years two or three of the strategic plan. Members made a number of suggestions that should be considered going forward, such as the impact of closer links between health and social care and developing links with local health networks,

26.6. In relation to the format of the report, the Council asked that the report should specify whether the RAG rating related to the progress to date or to the expected outcome if progress continued at that level. The Council also suggested that it would be helpful to include an introduction, providing an overview of the direction of travel, and to include a lead or sponsor for each area of work.

26.7. In relation to targets, the Council noted that the focus should continue to be on how the plan’s outcomes contribute to patient safety, rather than simple key performance indicators. DR commented that targets used throughout the performance monitoring scheme should be reviewed and updated in order to better reflect the workload and activities of the organisation.

26.8. ACTION: Council to be presented with an integrated and updated performance report at the September meeting.

26.9. The Council welcomed the new-style report and noted the work being undertaken to develop the monitoring and reporting scheme.

27. CHIEF EXECUTIVE & REGISTRAR’S REPORT

27.1. DR drew members’ attention to the items on rebalancing and pharmacy technician training. He reported that, for both, the GPhC’s approach would take into account the developing skills mix in pharmacy teams.

27.2. Responding to a members question about an HEE consultation on workforce planning Hugh Simpson (HS) said that the team had reviewed the consultation and the focus was not directly relevant to statutory functions. However, the GPhC would continue to discuss the wider issues around workforce with HEE directly.

27.3. Responding to a member’s question regarding memoranda of understanding and the survey of independent pharmacies, Hugh Simpson (HS). He reported that a survey had been carried out and that further information would be shared with Council once the data had been analysed.

27.4. ACTION: Results and analysis of survey of independent pharmacies to be circulated to members before September Council meeting.

27.5. ACTION: Criteria for responding to other bodies’ consultation to be circulated to members before September Council meeting.

27.6. The Council noted the report.
28. **PERFORMANCE OF ‘BLACK - AFRICAN’ CANDIDATES: JUNE 2013 REGISTRATION ASSESSMENT**

28.1. DD reported that the paper set out the GPhC’s first steps towards understanding the nature and potential causes of the differences in performance in specific groups of candidates.

28.2. DD drew members’ attention to the next steps that would be taken and reported that the findings of the survey of pre-registration candidates would be considered as part of this work going forward.

28.3. During the discussion, the Council noted that the experience and achievement of ‘Black-African’ pre-registration trainees was similar to that for other such candidates in post-compulsory education and training. DD pointed out that the GPhC would be able to gauge whether this was a persistent or isolated issue once the outcomes of the 2014 sitting were known.

28.4. The Council noted that there was a careful balance to be made between providing support for students who were thought to be more likely to struggle and avoiding any stigma or labelling of particular groups. The Council also noted other bodies, such as universities, colleges and training providers, had a significant role to play in improving performance.

28.5. **ACTION:** An update to be provided to Council in mid-2015.

28.6. **The Council noted the report.**

29. **REVISING INITIAL EDUCATION AND TRAINING STANDARDS FOR REGISTRANTS**

29.1. DD informed the Council that the workplan set out in the paper had been deliberately staggered so as to allow partners to develop their own work and form views.

29.2. In response to a member’s question, DD responded that the work would take into account the various forms of pharmacy training being used, such as integrated and non-integrated courses, and would ensure that the timetable of work would meet schools’ needs.

29.3. The Council noted that the introduction of continuing fitness to practise and the changing nature of roles within the pharmacy team would be taken into account as the work developed.

29.4. The Council queried whether it would be feasible to expedite the proposed timetable for reviewing the initial education and training of pharmacy technicians.

29.5. **ACTION:** A further review of the proposed timetable to be carried out.

29.6. **The Council noted the report.**
30. **Review of Associate Workers’ Remuneration**

30.1. Viv Murch (VM) reported that the paper was the culmination of the first comprehensive review of associates’ fees since the GPhC’s inception. The aim was to ensure that fees were fair while ensuring that high calibre candidates continued to be attracted to the roles. VM also drew members’ attention to a tabled paper providing a number of small corrections to the calculations set out in the original paper.

30.2. Liz Kay (LK), chair of the remuneration committee, reported that the committee has discussed the review in some detail over a number of meetings. This included consideration of the workload and time commitment required for each role. LK also drew members’ attention to the small number of outstanding matters that that would be addressed by the committee in the coming months.

30.3. The Council approved the recommendations set out in the paper.

31. **Remuneration Committee Annual Report to Council**

31.1. LK, chair of the remuneration committee, drew members’ attention to the key areas of work undertaken by the committee during the previous year.

31.2. The Council noted the annual report of the remuneration committee.

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

32.1. David Prince (DP), chair of the audit and risk committee outlined the main areas of work undertaken by the committee. DP drew members’ particular attention to the assurances provided by the internal and external auditors.

32.2. The Council noted the annual report of the audit and risk committee.

33. **Minutes of Audit and Risk Committee, 28 May 2014**

33.1. DP, chair of the audit and risk committee, informed the Council that the external auditors had reported that there were no significant issues raised during the audit.

33.2. The Council noted the assurance provided to and through the committee in respect of the fitness to practise performance.

33.3. The Council noted the minutes of the audit and risk committee.

34. **Annual Report and Accounts 2013-14**

34.1. The Council discussed the report and noted that it was well-written and a good reflection of the progress made during the year.

34.2. The Council approved the combined annual report, annual accounts and fitness to practise report 2013-14 and agreed that the accounts should be signed by the Chair.
34.3. The Council also authorised the Chair to sign the letter of representation as required by the auditors.

35. APPOINTMENT OF THE EXTERNAL AUDITORS
35.1. The Council approved the reappointment of Grant Thornton as external auditors.

36. STANDING ORDERS AND SCHEME OF DELEGATION
36.1. The Council agreed:
   i. that following review Standing Orders required no amendment;
   ii. delegation of authority to the Remuneration Committee for determining the remuneration and expenses policy applying to Associates;
   iii. the amendment of the scope of the delegated authority to the Board of Assessors for adjustments to include any protected characteristic;
   iv. to increase the length of appointments of members to the Audit and Risk and Remuneration Committees to up to two years.

37. ANY OTHER PUBLIC BUSINESS
37.1. The Chair confirmed that the meeting was moving into confidential business since some matters to be discussed were commercially confidential.
37.2. There being no further business, the part of the meeting that was held in public closed at 12:05.

DATE OF NEXT MEETING
Thursday 11 September 2014
Strategic Plan 2015-18

Purpose
To agree the GPhC strategic plan for 2015-2018.

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

1. Introduction
1.1 We have a statutory obligation to submit a strategic plan annually to the Privy Council Office, to be laid 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 The strategic plan agreed by Council this time a year ago was notably different from its predecessors, having taken a fresh look in light of significant developments in the environment in which we work.
1.4 The draft strategic plan proposed in this paper has been updated to reflect the changing nature of pharmacy and the wider context within which that change is taking place. Appropriately, in a document taking a high level view of the GPhC’s long term priorities, no major changes are proposed after just one year.

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 2015). 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 In particular, the proposed strategic plan has been updated to:
• Provide a more contemporary context and reflect our improvements, ambitions and how we’re moving forward;
• Include of a preamble to each strategic theme to bring out the nature and tone of our high level priorities;
• Acknowledge and address the themes of high profile cases and to reflect the diversity of approaches across the three countries;
• Strengthen our commitment to maintaining good engagement and high quality customer service;
• Share our learnings from data, information and intelligence gathered, to highlight issues and opportunities for improvement within pharmacy;
• Highlight how services are changing and the greater awareness of the speed of change so we are able to reassure the public that we have effective systems in place to meet their expectations;
• Identify the major changes in the health and social care sector and the role for community pharmacies; and
• Provide further assurance that future professionals, as well as those already registered, are able to meet the needs of patients and the public.

3. Equality and diversity implications

3.1 Each of the four key themes in the draft plan has equality, diversity and inclusion aspects which need to be analysed and reflected appropriately in the corporate and business planning which will flow from the strategic plan.

3.2 The draft plan specifically highlights the diversity in healthcare and pharmacy within and between the home countries of Great Britain and gives priority to our understanding and engaging effectively with different contexts in England, Scotland and Wales.

4. Communications

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. Resource 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.

6. Capacity and capability

6.1 Across all parts of the organisation we will need to keep reviewing whether we have adequate levels and amounts of staffing, and the right skills. We have already identified a significant development need specifically in relation to data analysis and statistics, business intelligence and knowledge management. 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.

7. Organisational development

7.1 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.

8. Risk implications

8.1 Our risk management approach focuses on the identification and management of risks to the achievement of the organisation’s objectives, derived from the strategic plan.

8.2 In terms of risk to the GPhC, having an up to date strategic plan is an essential component of our risk management approach which helps to reduce the likelihood of the GPhC wasting time and resources, provided by registrants, on activities and work which are not strategic priorities.

Recommendations

The Council is asked to agree the strategic plan which appears in draft at Appendix1.

Duncan Rudkin, Chief Executive & Registrar
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20 August 2014
General Pharmaceutical Council

Strategic plan
2015-2018
General Pharmaceutical Council

Strategic Plan
2015 - 2018

Strategic Plan presented to Parliament and the Scottish Parliament Pursuant to Paragraph 8 of Schedule 1 to the Pharmacy Order 2010
Contents
Foreword by the Chair and Chief Executive

Last year we published our first fundamental strategic review since our establishment in 2010. This strategic plan is an update to last year’s publication, taking into account external developments across Great Britain. These developments give cause for optimism, with a consensus building about the role that pharmacy must play if we are to meet the health challenges that face us, particularly wider public health challenges. However, there continue to be issues of great concern to us all, not least continuing high profile cases where patient care, particularly vulnerable patients, has been inadequate.

Our strategic plan last year explained our Council’s belief that while the individual decisions of pharmacy staff can make the most significant contribution to quality improvements in pharmacy and managing risks to patients, we do think we have a key part to play in helping pharmacy professionals and the pharmacy sector as a whole to improve quality, of which safety is a key element.

Everyone involved in healthcare, either through the provision of healthcare or the regulation of healthcare services and those professionals providing it must take full account of inquiries and reports into high profile failures. These include the report on Mid-Staffordshire NHS Foundation Trust, the Trusted to Care report into care at Abertawe Bro Morgannwg University Health Board, as well as the Inquiry into the Vale of Leven hospital. There are consistent themes around culture and the importance of professionalism, candour, and focus on patient care which we must all continue to keep at the front of our minds.

A positive development in the previous twelve months is the clear statements from ministers across Great Britain about the importance of unlocking the full potential of pharmacy as a whole, and the capacity of pharmacy professionals. This focus has been seen most notably through the publication of the Scottish Government’s report, A Prescription for Excellence, and NHS England’s Pharmacy call to action. The ambition within these reports and public policy in England, Scotland and Wales requires us to think about our role and the contribution we have to make. Furthermore the UK wide initiative looking at the balance between medicines legislation and professional regulation overseen by the Rebalancing Programme Board reminds us that public policy and regulation is dynamic and constantly changing. In particular these developments require us to consider:

- The knowledge and skills that are required of pharmacists and pharmacy technicians of the future and how our standards for the initial education and training of pharmacists and pharmacy technicians will need to change to address those.
• How we can use our privileged position as both a regulator of individual professionals and of pharmacy services provided from registered pharmacies, to share data, knowledge, information and insight into how pharmacy is changing so that positive developments and innovation can be shared, and risks identified and mitigated.

• The need to focus relentlessly on the needs of patients who are cared for by pharmacy professionals and receive advice, services and care from registered pharmacies; and how to promote professionalism and the delivery of compassionate and patient-centred care if we are to reduce instances of high profile failures in care.

The changes to the strategic plan from last year reflect the external developments referred to as well as the learning and data derived from our own work. There are many challenges facing healthcare in general and pharmacy in particular; this strategic plan is a clear statement about the contribution we, as the regulator, intend to play, as an active participate not as a passive observer in meeting these challenges.

Nigel Clarke, Chair
Duncan Rudkin, Chief Executive and Registrar
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 – of which safety is a critical element - 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 aim 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 2015-2018

Our regulatory approach is focused on outcomes for patients and the public. So too is our strategy. We want the outcomes of regulation to have a positive impact on public and patient health and wellbeing outcomes.

In order to achieve this 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

Proactive quality regulatory services mean that we continually challenge ourselves to maintain and improve and that we focus on what works, through effective measurement and evaluation.

In the timescale covered by this strategic plan:

- We will make significant measurable progress to resolve concerns about the fitness to practise of pharmacists and pharmacy technicians more quickly.
- 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 healthcare providers, the NHS, commissioners (where relevant), regulators and other relevant bodies throughout Great Britain to identify and tackle issues and risks to patients.
- 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 work to set standards for and quality assurance of education and training of pharmacy professionals, as well as work to assess their continuing fitness to practise will take full account of the wider needs of society and public health challenges to ensure future professionals as
well as those already registered are able to meet the needs of patients and the public.

**Putting people at the heart of what we do as a regulator**

*We aim to focus on outcomes rather than process, rules and regulations, administration or activity, all of which are means not ends. Our work is all about people – the people using and the people providing pharmacy services.*

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. It will also be informed by effective engagement with providers of pharmacy services and care including pharmacy professionals. This engagement will begin at the early development of ideas, right 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. Those staff working within pharmacy will also be increasingly able to speak up and raise concerns with senior staff or their employers and be confident in being honest with patients when things go wrong.

- We will listen to feedback and maintain a strong commitment to good engagement, high quality customer service ensuring that there are effective opportunities for feedback and that we demonstrate what we have done as a result.

**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**

*We see insight from data, information and intelligence as fundamental to the achievement of good regulatory outcomes. It will enable us to improve the efficiency and effectiveness of our own work and provide evidence of where change is needed to improve pharmacy.*

In the timescale covered by this strategic plan:
• 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.

• We will be publishing regular reports, based on our learning from data, information and intelligence gathered, to highlight issues and opportunities for improvement within pharmacy.

Using regulation to promote a culture of patient-centred professionalism in pharmacy

We believe that professionalism can provide the best protection for patients and the best way to encourage quality in pharmacy. Regulation cannot create professionalism but it can – working with others – help to create an environment within which professionalism can flourish.

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
  − the standards which we set for pharmacists, pharmacy technicians, pharmacy owners and superintendent pharmacists.

• We will ensure our own policy development including research and evaluation increasingly considers outcomes for patients and how patient-centred professionalism can make an impact.
Public business

Performance Monitoring Report

Purpose
To report to Council on operational and financial performance

Recommendations
The Council is asked to:

i. Note and comment on the executive summary and performance information presented at Appendix 1

ii. Comment on the revised performance reporting style

iii. Comment on the illustrative example for integrated corporate plan reporting at Appendix 2

2. Introduction

2.1 This paper reports on operational and financial performance to the end of July 2014. It provides an overall summary of the key points that Council should be aware of as well as presenting the data

2.2 This paper is the first performance report in the revised format and feedback from Council members on style and content are welcomed.

2.3 Feedback from the Council is also requested on the illustrative example of how in future progress against the corporate plan will reported and integrated with performance information (Appendix 2).

2.4 The sections below provide an executive summary for key areas to note within the report.

3. Registration

3.1 The pattern of registrations for pharmacists and pharmacy technicians remains in line with the annual expectations. The rise in numbers following
the assessment sitting in June is expected to be reflected in the coming months as per the previous year.

3.2 Council members will note the high value for the maximum number of days for between receipt of applications for both pharmacists and pharmacy technicians. This is due to European applications where documentation from the applicant is awaited.

4. Fitness to Practise (FtP)

4.1 The GPhC has continued to receive an increase in concerns with July representing the highest level received to date. Over the last 12 months there has been a 37% increase compared with the prior 12 month period. The largest proportion of concerns received continues to come from members of the public.

4.2 July 2014 has seen a significant improvement in the number of cases being closed, mirroring the planned implementation of improvements within FtP. Those improvements include: restructured teams since June, enhanced performance monitoring and additional capacity in teams. This has resulted in more cases being closed than received in July.

4.3 There has been a planned and targeted effort in closing cases over 12 months old and whilst this has inevitably increased the average age of closed cases it has also reduced the overall case age profile.

5. Planned review of operational targets in FtP and the inspection cycle

5.1 Our performance monitoring and reporting capabilities in fitness to practise have improved significantly over the last 12 to 18 months. As a result, we have begun to undertake a comprehensive and meaningful review of the single overarching operational target to conclude 95% of all cases within 12 months. The purpose of the review is to provide assurance to Council that the target is evidence based, realistic but stretching - given the context of a significant and continuing rise in the number of concerns we are receiving – without adversely impacting on quality, and which delivers openness and transparency. Initially the review has identified that the single operational target is not evidence based, and may not be realistic or achievable for those cases that conclude at a full fitness to practise hearing. These types of cases account for around 4.6% of the total caseload and average at 24 months before closure, reflecting the more serious nature of these types of cases and typically include those cases involving third parties which very often results in delays beyond our control.

5.2 Similarly, as the Council will be aware, the pharmacy premises inspection cycle currently operates on a three year cycle and that, as a result of a
number of factors (including the introduction of the prototype new inspection model) the number of pharmacies overdue for inspection is growing. The three year cycle was inherited from the RPSGB and the evidence base and rationale for it is not clear. As part of being an effective and proportionate regulator the GPhC is considering moving to a more targeted, risk based model for inspection.

5.3 It is proposed that the FtP operational target and the inspection cycle are reviewed with Council input and that a paper to approve any revisions is brought to the Council meeting in November 2014 for approval.

6. Human Resources
6.1 Council will note that, as predicted, there has been an increase in staff turnover. The factors behind this remain the imminent relocation, the expected cycle of staff who have been at the organisation since inception now seeking career progression and the upturn in the economy.

7. Finance
7.1 In terms of financial performance there were increases in both income and expenditure against budget. The operating result to the end of July is a surplus of £5K, a favourable variance of £56K against forecast.

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

9. Communications
9.1 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.

10. Resource implications
Resource implications are addressed within the report.
11. **Risk implications**

11.1 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.

11.2 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.

12. **Monitoring and review**

12.1 Council will receive a performance monitoring report at each meeting providing an update of the delivery of the GPhC’s regulatory functions and finances. Each quarter the Council will also receive an update on progress against the Corporate Plan.

**Recommendations**

The Council is asked to:

i. Note and comment on the executive summary and performance information presented at Appendix 1

ii. Comment on the revised performance reporting style

iii. Comment on the illustrative example for integrated corporate plan reporting at Appendix 2

---

*Duncan Rudkin, Chief Executive & Registrar*

*General Pharmaceutical Council*

duncan.rudkin@pharmacyregulation.org

*Tel 020 3713 7811*

*21 August 2014*
Appendix 1

Performance Monitoring Report
Reporting Period: end of July 2014
Contents
1. Registration .............................................................................................................. 3
2. Continuing Professional Development ................................................................. 6
3. Fitness to Practise (FtP) .................................................................................... 7
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5. Human Resources ............................................................................................... 14
6. Financial Performance ...................................................................................... 16
7. Accreditation Data .............................................................................................. 19
1. Registration

1.1 Register totals as at 31 July 2014

<table>
<thead>
<tr>
<th>Type</th>
<th>Pharmacists</th>
<th>Pharmacy Technicians</th>
<th>Premises</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>49,824</td>
<td>22,520</td>
<td>14,330</td>
</tr>
</tbody>
</table>

1.2 New registrations last 13 months: pharmacists and pharmacy technicians

Registrations by month

<table>
<thead>
<tr>
<th>Type</th>
<th>Jul 13</th>
<th>Aug 13</th>
<th>Sep 13</th>
<th>Oct 13</th>
<th>Nov 13</th>
<th>Dec 13</th>
<th>Jan 14</th>
<th>Feb 14</th>
<th>Mar 14</th>
<th>Apr 14</th>
<th>May 14</th>
<th>Jun 14</th>
<th>Jul 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacists</td>
<td>25</td>
<td>1,615</td>
<td>351</td>
<td>71</td>
<td>508</td>
<td>88</td>
<td>41</td>
<td>35</td>
<td>54</td>
<td>37</td>
<td>30</td>
<td>32</td>
<td>28</td>
</tr>
<tr>
<td>Pharmacy Technicians</td>
<td>92</td>
<td>121</td>
<td>294</td>
<td>139</td>
<td>159</td>
<td>147</td>
<td>99</td>
<td>89</td>
<td>80</td>
<td>83</td>
<td>50</td>
<td>62</td>
<td>78</td>
</tr>
</tbody>
</table>

- The profile of new Pharmacists and Pharmacy Technicians is very much in line with the normal annual pattern.
1.3 New Registration Application processing days for period August 2013 – July 2014

- The tables below show that approvals and registrations of new Pharmacists and Pharmacy Technicians are being processed in a timely way, within our targets.
- The high maximum values for pharmacist approval and registration processing days reflect European applications where we were waiting on outstanding documentation from the registrant to complete the process.

<table>
<thead>
<tr>
<th>Pharmacist</th>
<th>New Applications Registered</th>
<th>01/08/2013 - 31/07/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>Days</td>
<td></td>
</tr>
<tr>
<td>Application receipt to approval</td>
<td>Minimum</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Average</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td>73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Technician</th>
<th>New Applications Registered</th>
<th>01/08/2013 - 31/07/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>Days</td>
<td></td>
</tr>
<tr>
<td>Application receipt to approval</td>
<td>Minimum</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Average</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td>44</td>
</tr>
</tbody>
</table>
1.4 New registrations last 13 months: premises

- The growth in registered premises is very steady with no deviation in the trend of incremental increases in the number of premises.
- Our data base is not currently configured to record premises that leave the register on a month by month basis. We are working on being able to provide premises removal data in this way.
2. **Continuing Professional Development**

- We record the number of CPD forms requested and received and the overall compliance rate.
- We do not link the request date and the submission date so we cannot currently display the timeliness of CPD responses. We are working on adding this functionality.
- Compliance with mandatory CPD returns is in excess of 99%.

### CPD Volumes

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>1/14</th>
<th>2/14</th>
<th>3/14</th>
<th>4/14</th>
<th>5/14</th>
<th>6/14</th>
<th>7/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records Requested</td>
<td>4,612</td>
<td>4,798</td>
<td>4,236</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Records Submitted</td>
<td>1,389</td>
<td>3,173</td>
<td>4,596</td>
<td>3,783</td>
<td>1,167</td>
<td>189</td>
<td>95</td>
</tr>
</tbody>
</table>

- Of those Pharmacists who have supplied a CPD response this year, 99.6% passed.

### CPD Results

<table>
<thead>
<tr>
<th>Results</th>
<th>1/14</th>
<th>2/14</th>
<th>3/14</th>
<th>4/14</th>
<th>5/14</th>
<th>6/14</th>
<th>7/14</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results</td>
<td>75-100% (Excellent)</td>
<td>668</td>
<td>1,017</td>
<td>2,315</td>
<td>1,201</td>
<td>2,241</td>
<td>1,863</td>
<td>2,112</td>
</tr>
<tr>
<td>50-74% (Good)</td>
<td>27</td>
<td>39</td>
<td>50</td>
<td>37</td>
<td>59</td>
<td>52</td>
<td>53</td>
<td>317</td>
</tr>
<tr>
<td>25-49% (Look At Again)</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td>0-24% (Urgent Attention)</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Failure Rate %</td>
<td>0.9%</td>
<td>0.8%</td>
<td>0.3%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.5%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

- While compliance with the CPD requirements is very high, in reality compliance is obligatory in order to practise, so compliance does not equate to practising in accordance with best practice.
- There is work underway within the ‘Continuing Fitness to Practise’ work stream to assess how the GPhC might record more meaningful information to ensure that compliance equates to achievement of the right regulatory outcomes.
3. Fitness to Practise (FtP)

3.1 Concerns received

- Chart C illustrates that the trend in rising concerns continues. In July we received a record number of concerns at 142, with the largest proportion and increase continuing to come from members of the public. We will continue to monitor incoming concerns closely over the coming months.
3.2 Cases received vs. cases closed

- Performance in closing cases continues to improve. More cases were closed in July than we received, with a resultant reduction in the overall caseload, as illustrated by the caseload net change tracker below in chart D. This positive direction of travel mirrors the planned implementation of improvements within FtP, Those improvements include: restructured teams since June, enhanced performance monitoring and additional capacity in teams.

![Chart D](image)

3.3 Closed cases

- The average time to close cases has steadily improved throughout the year with a slight expected and planned increase in July, as a result of the focus on progressing older cases (over 12 months old) through to closure. Chart E demonstrates that we are starting to see the sustained benefits from a number of the process changes which have helped to improve the timeliness of different stages of the FtP process.

![Chart E](image)
3.4 Case closures by stage

- Table 6 and chart F below show the number of case closures by FtP stage from January to July 2014. The trend of increasing closures across all stages is clear from June 2014 where we believe a number of process and capacity improvements had begun to take effect.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OOJ</td>
<td>26</td>
<td>26</td>
<td>25</td>
<td>31</td>
<td>28</td>
<td>23</td>
<td>38</td>
</tr>
<tr>
<td>Stream 1</td>
<td>25</td>
<td>28</td>
<td>34</td>
<td>29</td>
<td>36</td>
<td>31</td>
<td>53</td>
</tr>
<tr>
<td>Stream 2</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>18</td>
<td>18</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>IC</td>
<td>2</td>
<td>14</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>FtPC</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>

3.5 Closures by type by month

![Chart F](chart)

Table 6

Chart F
3.6 Age profile of caseload – open cases

- Chart G shows the changing age profile of our open caseload. Our planned focus on proactively progressing cases over 12 months old through to closure is resulting in a reducing age profile of our open caseload in both 12 to 15 months and 15 months plus age categories, although this is also being driven by the influx of new work.
3.7 **Interim Orders**
- Chart H below shows the number of interim orders issued during this reporting period. The numbers tend to fluctuate month by month as an application for an interim order is driven by the receipt of information that suggests there may be a significant patient safety issues if the registrant continues to practise whilst an investigation is being undertaken. An interim order can also be applied for in the registrant’s best interests, and/or if it is in the public interest to do so. There is no significant trend to highlight from this reporting period.

![Chart H](image)

3.8 **Disclosure and Barring Service (DBS) referrals**
- The GPhC referred one case to the DBS for England and Wales in the reporting period.
3.9 Appeals

- There are four live appeals in this reporting period and one judicial review. The GPhC is awaiting the decision in one of these cases, with two others listed for October and the remaining appeal not having yet been listed for a hearing.
- Three appeals were closed in this reporting period, one of which resulted in the decision being referred back to the fitness to practise committee to reconsider and one other withdrawn by the registrant. The third case was appealed by the PSA, under their section 29 powers to refer a decision made by a fitness to practise panel, and was upheld resulting in the registrant being struck off.
- In the case where the decision was referred back to the fitness to practise panel to reconsider the sanction, the GPhC has lodged an appeal to the Supreme Court against the ruling of the court.
4. Organisational Complaints

- The level of complaints has reduced compared with the same Quarter last year:
- The key themes that are driving complaints are CPD communications, inadequate access to the concerns hotline and fee reminder correspondence.
5. Human Resources

5.1 Sickness

- The raw sickness data (with one individual on long-term sickness removed), shows the number of business days lost per month.

- Due to lack of confidence in departments consistently inputting all sickness absence, the above figures should be viewed with some caution. A new HR system is being introduced in November and managers will be reminded of their responsibilities in relation to absence reporting. Over a period of time these changes will be reflected through more accurate data capture and reporting.
5.2 Staff turnover

<table>
<thead>
<tr>
<th>Turnover for perm staff 1 August 2013 to 31 July 2014</th>
<th>16%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover for Fixed term staff 1 August 2013 to 31 July 2014</td>
<td>29%</td>
</tr>
</tbody>
</table>

- For the last two years our turnover has been between 9% and 11% however we are now seeing a predicted increase. The increase is due to:
  1) The impending move to Canary Wharf
  2) The number of staff who joined at the inception of the GPhC and who have been in post for over 3 years, and so are seeking new roles as a natural part of their career progression
  3) Economic recovery; more voluntary resignations within an increasingly candidate driven market.

- We will continue to monitor the turnover rate, which is currently above the 2013 public services rate of 11%.
6. **Financial Performance**

6.1 **Summary**

- The operating result to the end of July is a surplus of £5K, which is a favourable variance of £56K against forecast.

- Bank & Cash has decreased by 2m year-on-year as money has been spent on the fit-out of Canary Wharf, new office furniture, new computers and the MS Dynamic CRM project which has increased our fixed assets by £2.0m since the end of last financial year.

- The free reserves currently sit at 14.1m. By 31st March 2015 the free reserves will have reduced to £11.9m. This is due to the high levels of capital expenditure.

- Landlord Incentives of £1.1m represent the amount that the landlord has contributed to date towards the fit-out costs for Canary Wharf. The landlord is meeting 85% of these costs. They will be credited over 10 years to the Income & Expenditure Account, thus reducing the cost of renting Canary Wharf by c. £450k per year.

6.2 **Income**

- Fee income is ahead of forecast due to registration fees in July being £114k more than forecast. This fee income was expected in August but arrived in late July as new Pharmacy Graduates paid their application fees in order to get onto the Register. Application fees are recognised in the accounts in the month they are received.

- Interest Income is £16K more than forecast as we underestimated the interest income which should be recognised in 14-15 so far. There were also two additional accreditation prescribing events which took place in July which were not included in the original forecast which has generated an additional £10K under other income.

6.3 **Expenditure**

- Expenditure FYTD is £81K higher than forecast, with the greatest overspend being incurred in professional fees (£57K). This includes an IT overspend (£17k) linked to the office move and an overspend (£30K) related to a larger than expected internal audit bill for services provided in 13-14. These additional services have caused an overspend in the Resources & Customer Services directorate.

- There has also been an overspend (£12k) in shorthand report writing, medical reports and witness expenses due to an increase in the number of hearings causing a variance in the Inspections & Fitness to Practise directorate.

- There is also an overspend (£12K) in occupancy costs as the costs for Bell House were underestimated at forecast.
### GPhC Balance Sheet as at 31 July 2014

<table>
<thead>
<tr>
<th></th>
<th>July 2014</th>
<th>March 2014</th>
<th>July 2013</th>
</tr>
</thead>
<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>2,780</td>
<td>727</td>
<td>242</td>
</tr>
<tr>
<td></td>
<td>2,780</td>
<td>727</td>
<td>242</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade Debtors</td>
<td>29</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other Debtors</td>
<td>85</td>
<td>267</td>
<td>201</td>
</tr>
<tr>
<td>Prepayments</td>
<td>919</td>
<td>718</td>
<td>568</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>165</td>
<td>124</td>
<td>164</td>
</tr>
<tr>
<td>Escrow Account</td>
<td>595</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bank &amp; Cash</td>
<td>24,174</td>
<td>29,667</td>
<td>26,139</td>
</tr>
<tr>
<td></td>
<td>25,967</td>
<td>30,780</td>
<td>27,075</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade Creditors</td>
<td>134</td>
<td>822</td>
<td>528</td>
</tr>
<tr>
<td>Corporation Tax</td>
<td>86</td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td>Other Creditors</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other Taxes &amp; Social</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security</td>
<td>209</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>Deferred Income :-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Grants</td>
<td>1,272</td>
<td>1,295</td>
<td>1,517</td>
</tr>
<tr>
<td>- Ring Fenced Grant</td>
<td>76</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>- DH Grants</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>- Fee Income</td>
<td>9,348</td>
<td>12,483</td>
<td>8,832</td>
</tr>
<tr>
<td>- Other Income</td>
<td>6</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Accruals</td>
<td>754</td>
<td>746</td>
<td>607</td>
</tr>
<tr>
<td></td>
<td>11,892</td>
<td>15,713</td>
<td>11,642</td>
</tr>
<tr>
<td><strong>Net Current Assets / (Liabilities)</strong></td>
<td>14,075</td>
<td>15,068</td>
<td>15,432</td>
</tr>
<tr>
<td><strong>Long Term Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Landlord Incentive</td>
<td>1,055</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>15,800</td>
<td>15,795</td>
<td>15,674</td>
</tr>
<tr>
<td><strong>Funds Employed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated Fund b/fwd.</td>
<td>15,795</td>
<td>14,642</td>
<td>14,642</td>
</tr>
<tr>
<td>Surplus/(Deficit) in Year</td>
<td>5</td>
<td>1,153</td>
<td>1,045</td>
</tr>
<tr>
<td>Prior Year Adjustment</td>
<td></td>
<td></td>
<td>(13)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Funds</strong></td>
<td>15,800</td>
<td>15,795</td>
<td>15,674</td>
</tr>
</tbody>
</table>
## Management Accounts by cost type - July 2014

<table>
<thead>
<tr>
<th>Cost Type</th>
<th>Actual</th>
<th>Forecast</th>
<th>Variance</th>
<th>Actual</th>
<th>Forecast</th>
<th>Variance</th>
<th>Full Year</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pharmacist Income</td>
<td>1,133,412</td>
<td>1,019,372</td>
<td>114,040</td>
<td>4,111,395</td>
<td>3,997,355</td>
<td>114,040</td>
<td>12,613,478</td>
<td>12,678,425</td>
</tr>
<tr>
<td>- Premises Income</td>
<td>290,998</td>
<td>293,618</td>
<td>(2,620)</td>
<td>1,139,815</td>
<td>1,142,435</td>
<td>(2,620)</td>
<td>3,391,521</td>
<td>3,380,583</td>
</tr>
<tr>
<td>- Technician Income</td>
<td>216,155</td>
<td>222,837</td>
<td>(6,683)</td>
<td>851,531</td>
<td>858,213</td>
<td>(6,683)</td>
<td>2,531,297</td>
<td>2,612,535</td>
</tr>
<tr>
<td>- Pre-Registration Income</td>
<td>43,672</td>
<td>37,867</td>
<td>5,806</td>
<td>614,988</td>
<td>609,182</td>
<td>5,806</td>
<td>1,021,646</td>
<td>1,008,921</td>
</tr>
<tr>
<td>- Other Fee Income</td>
<td>6,494</td>
<td>8,131</td>
<td>(1,637)</td>
<td>26,416</td>
<td>28,053</td>
<td>(1,637)</td>
<td>149,065</td>
<td>118,268</td>
</tr>
<tr>
<td>- DH Grant Income</td>
<td>2,634</td>
<td>2,487</td>
<td>147</td>
<td>22,574</td>
<td>22,427</td>
<td>147</td>
<td>234,892</td>
<td>165,657</td>
</tr>
<tr>
<td>- Other Income</td>
<td>23,273</td>
<td>10,679</td>
<td>12,594</td>
<td>138,070</td>
<td>125,476</td>
<td>12,594</td>
<td>274,209</td>
<td>303,380</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>1,716,638</td>
<td>1,594,991</td>
<td>121,647</td>
<td>6,904,788</td>
<td>6,783,141</td>
<td>121,647</td>
<td>20,216,108</td>
<td>20,267,769</td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chief Executive</td>
<td>(118,807)</td>
<td>(116,244)</td>
<td>(2,563)</td>
<td>(422,442)</td>
<td>(419,878)</td>
<td>(2,563)</td>
<td>(2,170,855)</td>
<td>(1,538,552)</td>
</tr>
<tr>
<td>- Policy &amp; Communications</td>
<td>(251,350)</td>
<td>(261,107)</td>
<td>9,757</td>
<td>(989,227)</td>
<td>(998,984)</td>
<td>9,757</td>
<td>(3,313,328)</td>
<td>(3,404,714)</td>
</tr>
<tr>
<td>- Inspections &amp; Fitness to Practise</td>
<td>(549,061)</td>
<td>(535,912)</td>
<td>(13,149)</td>
<td>(2,102,341)</td>
<td>(2,089,192)</td>
<td>(13,149)</td>
<td>(6,496,325)</td>
<td>(6,557,546)</td>
</tr>
<tr>
<td>- Council &amp; Governance</td>
<td>(74,545)</td>
<td>(73,044)</td>
<td>(1,501)</td>
<td>(217,626)</td>
<td>(216,125)</td>
<td>(1,501)</td>
<td>(751,889)</td>
<td>(783,898)</td>
</tr>
<tr>
<td><strong>Total Directorate Costs</strong></td>
<td>(1,606,278)</td>
<td>(1,537,507)</td>
<td>(68,771)</td>
<td>(6,291,109)</td>
<td>(6,222,337)</td>
<td>(68,771)</td>
<td>(20,208,207)</td>
<td>(20,218,367)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Occupancy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rent</td>
<td>(156,041)</td>
<td>(151,656)</td>
<td>(4,386)</td>
<td>(445,800)</td>
<td>(441,414)</td>
<td>(4,386)</td>
<td>(1,482,099)</td>
<td>(1,376,055)</td>
</tr>
<tr>
<td>- Contribution from Landlord</td>
<td>36,724</td>
<td>36,724</td>
<td>0</td>
<td>92,216</td>
<td>92,216</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Service Charge</td>
<td>(25,135)</td>
<td>(22,214)</td>
<td>(2,921)</td>
<td>(150,948)</td>
<td>(148,027)</td>
<td>(2,921)</td>
<td>(650,251)</td>
<td>(428,815)</td>
</tr>
<tr>
<td>- Rates</td>
<td>(17,257)</td>
<td>(17,255)</td>
<td>(2)</td>
<td>(69,028)</td>
<td>(69,026)</td>
<td>(2)</td>
<td>(393,439)</td>
<td>(285,651)</td>
</tr>
<tr>
<td>- Utilities</td>
<td>(10,702)</td>
<td>(6,223)</td>
<td>(4,479)</td>
<td>(25,233)</td>
<td>(24,754)</td>
<td>(4,479)</td>
<td>(129,814)</td>
<td>(96,998)</td>
</tr>
<tr>
<td>- Insurance</td>
<td>(8,071)</td>
<td>(8,062)</td>
<td>(9)</td>
<td>(22,279)</td>
<td>(22,270)</td>
<td>(9)</td>
<td>(85,468)</td>
<td>(75,613)</td>
</tr>
<tr>
<td>- Service Level Costs</td>
<td>(8,963)</td>
<td>(8,900)</td>
<td>(63)</td>
<td>(35,853)</td>
<td>(35,790)</td>
<td>(63)</td>
<td>(50,000)</td>
<td>(106,253)</td>
</tr>
<tr>
<td><strong>Total Occupancy Costs</strong></td>
<td>(189,445)</td>
<td>(177,586)</td>
<td>(11,859)</td>
<td>(660,924)</td>
<td>(649,065)</td>
<td>(11,859)</td>
<td>(2,801,071)</td>
<td>(2,369,387)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>(1,795,723)</td>
<td>(1,715,093)</td>
<td>(80,630)</td>
<td>(6,952,033)</td>
<td>(6,871,402)</td>
<td>(80,629)</td>
<td>(23,009,278)</td>
<td>(22,587,754)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Operating Surplus/(Deficit) before interest &amp; tax</strong></td>
<td>(79,085)</td>
<td>(120,102)</td>
<td>41,016</td>
<td>(47,245)</td>
<td>(88,261)</td>
<td>41,016</td>
<td>(2,793,170)</td>
<td>(2,319,985)</td>
</tr>
<tr>
<td>- Interest Receivable</td>
<td>25,851</td>
<td>10,000</td>
<td>15,851</td>
<td>63,683</td>
<td>47,831</td>
<td>15,851</td>
<td>207,420</td>
<td>156,683</td>
</tr>
<tr>
<td><strong>Net Operating Surplus/(Deficit) before tax</strong></td>
<td>(53,234)</td>
<td>(110,102)</td>
<td>56,868</td>
<td>16,438</td>
<td>(40,430)</td>
<td>56,868</td>
<td>(2,585,750)</td>
<td>(2,163,303)</td>
</tr>
<tr>
<td><strong>Net Operating Surplus/(Deficit) after tax</strong></td>
<td>(56,323)</td>
<td>(112,275)</td>
<td>55,952</td>
<td>5,257</td>
<td>(50,695)</td>
<td>55,952</td>
<td>(2,629,555)</td>
<td>(2,193,890)</td>
</tr>
</tbody>
</table>

Table 9
7. Accreditation Data

7.1 Summary of accreditation/recognition activity in 2013-2014

<table>
<thead>
<tr>
<th>Course</th>
<th>Event type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPharm degree</td>
<td>reaccreditation</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>3</td>
</tr>
<tr>
<td>MPharm 2+2 degree:</td>
<td>reaccreditation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy Foundation degree</td>
<td>reaccreditation</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>-</td>
</tr>
<tr>
<td>OSPAP:</td>
<td>reaccreditation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>-</td>
</tr>
<tr>
<td>Independent prescribing:</td>
<td>reaccreditation</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>3</td>
</tr>
<tr>
<td>Independent prescribing conversion:</td>
<td>reaccreditation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td></td>
</tr>
<tr>
<td>Pharmacy technician:</td>
<td>reaccreditation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>/recognition</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>/recognition</td>
<td>-</td>
</tr>
<tr>
<td>Dispensing assistant:</td>
<td>reaccreditation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>-</td>
</tr>
<tr>
<td>Medicines counter assistant:</td>
<td>reaccreditation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>accreditation</td>
<td>-</td>
</tr>
</tbody>
</table>

- The increase in the usually static number of independent prescribing programmes is the positive result of regional awareness programmes (bold and underlined figure above)
- In addition to the activities reflected in the above table, GPhC has also conducted its first five pilot interim visits to test the new accreditation methodology. The feedback has been positive, with the clinical focus providing insight into the quality of training.
Q2 2014/15 Corporate Plan and Performance Update

Introduction: The GPhC has agreed a corporate plan to support the delivery of its strategic themes. The corporate plan consists of six key priorities which are:

1. Being people/patient focussed
2. Providing proactive, proportionate and good-quality regulation
3. Promoting professionalism
4. Being accessible
5. Understanding our regulated community’s and patient’s needs
6. Being an efficient and effective organisation

Updates on the work programme to deliver these priorities are supported by operational delivery data and progress reports on key initiatives.

Key success: Overall this quarter we have...

Challenges: Progress had been effected by...

Responding to Council’s comments: At its last review Council requested...

Progress at a glance:

<table>
<thead>
<tr>
<th>Priority</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current RAG</td>
<td>Amber</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Amber</td>
<td>Green</td>
</tr>
<tr>
<td>Direction of travel</td>
<td>←</td>
<td>↑</td>
<td>←</td>
<td>←</td>
<td>↑</td>
<td>←</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiative Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Not started</td>
</tr>
<tr>
<td>Red</td>
<td>Off track and project at risk</td>
</tr>
<tr>
<td>Amber</td>
<td>Minor issues but achievable</td>
</tr>
<tr>
<td>Green</td>
<td>On track/completed</td>
</tr>
</tbody>
</table>
Proactive, proportionate and good-quality regulation

Objective 3: Ensure that concerns raised with us about the fitness to practise of pharmacists and pharmacy technicians are resolved safely, fairly and in a timely manner

What does success look like?

- Streamlined, efficient and effective fitness to practise case pathway
- Policy and guidance supports good concerns management
- Performance management framework in place so that cases are adequately resourced and progressed
- Transparent processes and clear public communication

Initiatives to deliver success:

<table>
<thead>
<tr>
<th>RAG Direction of travel</th>
<th>Amber</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of LEAN review projects</td>
<td>●</td>
</tr>
<tr>
<td>Improving on-line public concerns form</td>
<td>●</td>
</tr>
<tr>
<td>Enhancing performance management framework</td>
<td>●</td>
</tr>
<tr>
<td>Reviewing and updating policy and operational guidance</td>
<td>●</td>
</tr>
<tr>
<td>Developing new case management systems within CRM</td>
<td>●</td>
</tr>
</tbody>
</table>

Supporting data (impact):

Commentary: Progress towards improving the timeliness of concluding fitness to practise concerns continues to be positive over this reporting period. Initiatives remain on track with the development of the new case management system scheduled to commence in October as planned. Early signs of a step change in performance following restructuring in June and impact of some LEAN improvements. The volume of concerns received continues in an upward trend, with the majority of the concerns continuing to be from members of the public. Improvements to the online concerns form has led to a significant increase in the receipt of online complaints. The types of concerns being reported has not changed significantly with misconduct remaining as the largest proportion. As a result of the increasing concerns the open case load has increased, by 43% in the last twelve months, however progress has been made in reducing those cases over 12 months, reducing the overall age profile. Closure rates and productivity are improving. Key delays for cases over 12 months have been identified as third parties and internal delays and health cases. In July 2014 the number of cases closed exceeded the number of new cases opened. Overall the trend is likely to remain amber as the focus on closing the number of over 12 month cases will adversely impact the percentage target but will continue to reduce the overall age profile.
Reporting on the June 2014 Registration Assessment

Purpose
To update Council on candidate performance in the June 2014 Registration Assessment and related matters.

Recommendations
The Council is asked to note reports from the GPhC and Board of Assessors and associated actions by the GPhC.

1. Introduction
1.1 Passing the GPhC’s Registration Assessment is a pre-requisite for applying to register as a pharmacist\(^1\). There are two sittings every year, in June and September. This paper discusses the June 2014 sitting.

1.2 Two reports are presented here: the full Board of Assessors’ report to the GPhC (Appendix 1) and a summary of the GPhC’s report on candidate views of the sitting.

2. Reports
2.1 *Report from the Board of Assessors to the GPhC.* Broadly speaking, the report is positive. The papers performed well and there were only two significant issues: the performance of ‘Black-African’ candidates and the date of the June 2015 sitting, which falls in the middle of Ramadan. Both are discussed below.

2.2 *The performance of ‘Black-African’ candidates:* In June 2013 and again in June 2014, self-designated ‘Black-African’ candidates performed significantly less well than other candidates. The GPhC followed this up in late 2013 by contacting schools with high failure rates for these students, as Council is

\(^1\) Except for EEA pharmacist applicants.
aware. School strategies for dealing with underperformance were outlined in a previous paper.

2.3 We will be investigating this issue further in 2014-2015 and our next step will be to co-host a seminar in January 2015 on the performance of black and minority ethnic (BME) students with the Equality Challenge Unit, whose remit is to support equality and diversity for staff and students in higher education (http://www.ecu.ac.uk). All schools and pre-registration training leads will be invited.

2.4 The positioning of the June 2015 sitting: Every year, Ramadan begins two weeks earlier than in the previous year. This year it began just after the June sitting and in 2015 the sitting is scheduled to be in the middle of it. The 52-week 2014-2015 pre-registration training period has begun already and trainees are locked in to contracts, so it is not feasible to move the sitting to either before or after it.

2.5 To understand the implications of holding a sitting during Ramadan, the GPhC sought advice from (1) a Muslim adviser at a university with a school of pharmacy with a large number of Muslim students and (2) the Chief Imam of the Central London Mosque. Their view was that as the Registration Assessment is a unique event for most candidates, holding it during Ramadan would not be an insurmountable problem: Muslim candidates could make personal arrangements to meet relevant religious requirements and sit the Registration Assessment on the usual day.

2.6 By way of illustration, the Chief Imam was asked three questions:

1. whether people could travel during Ramadan?
2. whether people had to fast during Ramadan?; and
3. whether there are any other issues we should take into consideration?

His responses were:

1. ‘There is no bar on travelling during Ramadhan.
2. Fasting is compulsory for all men and women however there are exceptions. Those who are travelling, or sick or feel unable to fast are exempt. These fasts can either be made up later in the year or compensations paid to the poor, needy and the underprivileged.
3. Anyone who finds it hard to fast for a reason, is exempt (like a surgeon who will be doing a complicated operation and thinks that fasting might affect his concentration). It is entirely up to the individual. Choice has been left to the individual.’
2.7 On the basis of this advice and the recommendation of the Board of assessors (see Appendix 1), it was decided (1) to leave the sitting on the final Friday in June, (2) to reschedule the day slightly so that 1-2pm would be free for prayer, (3) to ensure that there would be time on either side for candidates to relax and to reregister for the afternoon paper and (4) to explain the decision to candidates well in advance. Note that all assessment venues have prayer rooms.

2.8 Making adjustments on religious grounds: More generally, the GPhC is aware of its legal responsibility to make reasonable adjustments to the Registration Assessment based on the requirements of candidates with religious needs. We have made adjustments of this kind in the past.

2.9 GPhC report on candidate views of the sitting. For the last three years, the GPhC’s Customer Services Division has surveyed candidates about their experience of a sitting. After the June 2014 sitting, 479 candidates completed the survey, 18.8% of the total. The overall satisfaction rating was 89.9% and only one satisfaction rating, for cloakroom facilities, was <70%.

2.10 Positioning of the Registration Assessment during the week: Partly in response to the Ramadan issue discussed above, June 2014 candidates were asked if they had a preference for where the Registration Assessment should be positioned in the week and the clear majority preference was for Friday. Candidates appreciated having the whole week to revise before the sitting and that they could relax over the weekend afterwards. <10 candidates pointed out that Friday was a day of prayer for some religions but none went so far as to suggest that Friday should not be used on those grounds.

2.11 Candidate withdrawals before the sitting: In 2013 the GPhC introduced a ‘fit to sit’ policy, the essence of which is that candidates should only sit if they are fit to do so and, if they are not, should withdraw and bank the sitting. (If a candidate withdraws before a sitting begins, it does not count towards their total number of attempts, which is capped at three.) The policy was introduced in response to an increasing number of post hoc, groundless appeals against failure. The policy appears to have worked, in that the number of withdrawals has risen significantly this year. This may be an indication that candidates are exercising their professional judgement by deciding not to sit rather than risking failure.

3. Equality and diversity implications

3.1 The performance of ‘Black-African’ candidates has been highlighted in the Board’s report and the GPhC’s comments are included in this paper.
4. Communications

4.1 The Board’s report will be shared with schools of pharmacy and pre-registration training providers.

4.2 Pre-registration trainees will be informed of the GPhC’s decision about the positioning of the June 2015 Registration Assessment sitting in the first pre-registration bulletin, in November 2014.

4.3 The GPhC will ensure that the messaging is clear about which issues might be of concern to Muslim students and also how they might be addressed.

5. Resource implications

5.1 There are no resource implications, other than the costs associated with running the seminar mentioned in 2.3 above.

6. Risk implications

6.1 There is a risk that some candidates will not agree with the GPhC’s decision to leave the June 2015 sitting in its usual place and may ask for it to be moved for them. In mitigation, the due diligence and rationale behind the decision are explained in this paper.

Recommendations

The Council is asked to note reports from the GPhC and Board of Assessors and associated actions by the GPhC.

Damian Day, Head of Education
General Pharmaceutical Council
damian.day@pharmacyregulation.org

19 August 2014
Board of Assessors’ report to the General Pharmaceutical Council –
June 2014 Registration Assessment

1. Introduction

1.1 The initial education and training of pharmacists in Great Britain is:
- an accredited four-year MPharm degree; 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. Role of the Board of Assessors

2.1 The GPhC is responsible for running its national Registration Assessment. Operational matters are deal with internally but papers are set by an independent, appointed body, the Board of Assessors.

2.2 The Board comprises a chair and deputy chair, both pharmacists, and nine other pharmacist members (a mixture of academic pharmacists and pharmacists in practice). Two other members of the Board are non pharmacists but both are assessment experts: one is a medic and the other is a consultant in healthcare assessment.

2.3 All decisions about questions, papers, candidates and pass marks are made by the Board.

---

1 Non-EEA pharmacists study on a 1-year Overseas Pharmacists’ Assessment Programme (OSPAP), not an MPharm degree.
2.4 The Board is supported by the GPhC’s Education team.

3. Reporting to the GPhC

3.1 The Board of Assessors produces two reports for the GPhC annually, one after each of this sittings in June and September.

3.2 This report relates to the June 2014 sitting.

4. June 2014 statistics

A. All candidate numbers

<table>
<thead>
<tr>
<th>No. of candidates sitting</th>
<th>2,549</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of first sitting candidates</td>
<td>2,377</td>
</tr>
<tr>
<td>Number of second sitting candidates</td>
<td>89</td>
</tr>
<tr>
<td>Number of third sitting candidates</td>
<td>83</td>
</tr>
</tbody>
</table>

B. All candidate performance 1 - % pass/fail

- 2,175 candidates passed and 374 candidates failed.
- This year’s pass rate of 85.3% is close to the 10-year average for 2003-2013 of 88.5%. Last June’s pass rate was lower at 78%.
C. **All candidate performance 2 – pass rate by attempt**

- As anticipated, resit candidates performed less well than first attempt candidates. Note that the pass rate for 3rd attempt candidates is higher than for 2nd attempt candidates, which is atypical (but not statistically significant, given the numbers involved).
- Note that the following figures refer to first attempt candidate performance.

D. **First attempt candidate performance 3 – home students vs OSPAP students**

- There is a 2% difference between candidates who studied wholly in GB (‘Home’ candidates) and candidates whose primary pharmacy qualification was gained outside the EEA (‘OSPAP’ candidates).

E. **First attempt candidate performance 4 – performance by gender**

- [Data representation]

- [Data representation]
• Female candidates performed better than male candidates by 4%.
• 1536 candidates were female and 841 were male.

F. **First attempt candidate performance 5 – performance by country of training**

- There is a difference in performance between countries, as is usually the case.
- As a board we can only speculate why the pass rate is lower in England than it is in other two countries: it may be that there is just more natural variation in larger numbers and/or that the large independent community training sector is less well supported in England than it is in Scotland and Wales.
- Moving forward, the GPhC’s annual surveys of pre-registration training may help explain the variability in pass rates.

G. **First attempt candidate performance 6 – first attempt performance by training sector**

- Note that there were 672 hospital-based candidates (28.3% of the total number of candidates), 1697 community-based candidates (71.4%) and 8 industry or academia candidates (0.3%). As is usually the case, the pass rates confirm that hospital-based candidates perform better than community-based candidates.
• This figure presents data on the performance of the main self-designated ethnic categories. Other categories, with <100 members, have been excluded on the basis that the data are less reliable for less populous categories.

• The national pass rate is higher this year than last year but the rank ordering of pass rates by ethnicity has changed very little. As was the case in June 2013, the performance of ‘Black – African’ candidates is conspicuously lower than for other candidate categories. It should be noted that these candidates are not just those who trained overseas but also those who studied on GB MPharm degrees.

5. Discussion of the papers by the Board

5.1 Routine quality assurance of the paper: After a sitting, all questions and the papers as a whole are analysed by the Board. As a result of the post-sitting analysis for June 2014, one question was removed from the open book paper but none were removed from the closed book paper. In the case of two questions, one in each of the papers, two answers were accepted. The net effect of these changes was that the overall pass rate was raised by 1.6%.

5.2 Pass mark: The Board considered (1) the pass mark for the Assessment as a whole and (2) the calculations pass mark and agreed that there was no justification for adjusting either.

5.3 Feedback from the BPSA: The BPSA’s feedback was that very few issues had been raised with them and those that had were not substantive.

5.4 Ramadan 2015: In 2015 the June sitting is in the middle of Ramadan. The Board was briefed on background work undertaken by the GPhC on this matter - specifically to consider whether the sitting date could or should be moved.
The Board noted that moving the sitting to either before or after Ramadan would require the pre-registration training period to be moved for everyone. The Board agreed that to do this was not realistic – partly because 2014-2015 pre-registration training had begun already.

The Board noted that the GPhC had asked all June 2014 candidates which day of the week they would prefer the Registration Assessment to be scheduled on and that the overwhelming preference was for Friday. A small number (<10) noted that Friday was a day of prayer for some religions but none went so far as to suggest that it should be moved to another day on that basis. The Board noted that the GPhC had consulted a Muslim adviser at a university with a large Muslim student population and the Chief Imam of the Central London Mosque about running an examination in Ramadan and the advice from both of them was that it was acceptable, on an exceptional basis.

For these reasons, the Board advised the GPhC to run the June 2015 assessment on the last Friday in the month as usual but to rearrange the day slightly to ensure that 1-2 was free for prayer and that there was time on either side to relax and to reregister for the afternoon session.

Board of Assessors

15th August 2014
Public business

Council Appointments Progress Report

Purpose
To update the Council on the work of the Council appointments working group and seek approval of its proposals.

Recommendations
The Council is asked to:

i. note the report of the Council appointments working group;

and agree that:

ii. the person specification for a Council member or Chair of Council, including essential criteria and any desirable criteria, be approved by the Council;

iii. an appointments element, covering both Council and associate recruitment, be incorporated in the organisation’s communications work;

iv. a mixed approach be taken to promoting diversity among candidates based on: reviewing advertising and publicity; simplifying the application process where possible, and broader community engagement.

1. Introduction

1.1 The Council agreed terms of reference for the Council appointments working group in April 2014; these are attached at appendix 1 for ease of reference. This paper sets out the group’s proposals to date and provides an update on the group’s work, which has been informed by a review of the most recent appointment process and by the Professional Standards Authority (PSA) guidance on good practice in making Council appointments.

1.2 It will be seen that a number of aspects of the group’s work have relevance to the appointment processes for GPhC associates as well as Council members. The group will not look at processes for associates in any detail.
but intends, near the conclusion of its work, to draw out overarching conclusions applying to Council and associate recruitment. It is important to note that the recruitment of Council members is overseen by the PSA whereas the recruitment of associates is not.

1.3 Other matters to be considered by the group include: a reappointment process for Council members; the process and application form content for Council appointments, and the appraisal process for Council members. The Council will receive a further progress report in November 2014 and the group’s work is due for completion in February 2015.

2. **Setting the criteria for Council recruitment**

2.1 One of the most important aspects of a recruitment process is the person specification. This sets out the criteria to be applied when candidates are assessed. The specification may include both essential criteria which all successful candidates must meet, and desirable criteria to help ensure that the mix of backgrounds, experience and skills on the Council will meet the organisation’s current and future needs.

2.2 The group has considered the governance arrangements for setting these criteria and concluded that the Council itself is best placed to do so, provided that any conflicts of interest are managed appropriately. The group also discussed who would give final approval to the person specification if it needed to be adjusted following consideration by the Council but believes that this should be determined by the Council on a case by case basis, as different options would apply according to circumstances. For example, if the specification related to Council members, the Council might delegate final approval to the Chair of Council. If, however, the specification related to recruitment of a Chair, this would not seem appropriate but the Council could, for example, delegate final approval to the chair of a working group. The group plans to produce guidance on the factors to be taken into consideration when deciding who should give final approval to a person specification for a Council appointment, to help ensure consistency in decision-making: this would form part of a governance procedure.

3. **Communications with stakeholders**

3.1 The group was also asked to look at how best to obtain stakeholders’ views to inform our approach to Council appointments, bearing in mind the PSA’s guidance that stakeholders should have an opportunity to make their views heard but should not be able directly to influence selection decisions. Engaging with stakeholders should help to publicise upcoming vacancies and promote interest in them, as well as gaining feedback and suggestions to improve our appointments processes, such as ascertaining what discourages prospective candidates and seeking stakeholders’ views on desirable criteria for Council members.
3.2 Incorporating an appointments element – relating to both Council and associate roles – into the organisation’s existing broader communications work would seem the most effective means, being likely to reach more stakeholders and generate greater interest than a specific exercise on Council appointments, while having the potential to encourage a wider range of people to think about working with the GPhC.

3.3 Further consideration will be given to how best to incorporate an appointments element into the GPhC’s communications work, so as to produce feedback which can be taken into account in the next recruitment round.

4. Promoting diversity

4.1 The GPhC is committed to promoting equality, valuing diversity and being inclusive in its work. This is a continuous thread running through both Council and associate recruitment. The group has reviewed the potential for increasing the diversity among applicants for Council appointments and proposes that a mixed approach be taken to promoting diversity among candidates for both Council and associate positions, incorporating elements such as:

   i. reviewing the effectiveness and value of advertising and publicity used previously and considering new options;

   ii. simplifying the application process where possible and making it more accessible to candidates who have not held similar positions previously; and

   iii. seeking opportunities for broader community engagement.

5. Potential role of a recruitment agency and use of external search

5.1 Council recruitment exercises generate high volumes of enquiries and applications. The question of whether to use an agency or other additional resource to assist the process will be a management decision. With the aim of informing any tendering process, the group identified three aspects to be considered: routine processes to be performed to high standards of quality and speed; areas where more judgement and guidance is required, such as the initial sift of candidates, and external search.

6. Due diligence

6.1 Due diligence on Council candidates is an important factor in promoting public confidence in regulation. In reviewing the appointments process, the group noted the need to check relevant internal documented evidence on candidates, without involving staff in the selection process. This would entail checking performance records for any candidates who were currently working as GPhC associates, or had previously been an associate or employee.
7. **Equality and diversity implications**

7.1 The processes used in Council appointments should be objective, impartial and applied consistently. Processes should promote equality and be free from discrimination, harassment and victimisation. The working group will continue to keep these principles in mind as it carries out its work and is seeking to promote diversity through the appointments process as described above.

8. **Communications implications**

8.1 The Council recruitment and selection process is overseen by the PSA, which is being kept informed of the group’s work and Council decisions. The PSA has indicated that there appears to be nothing in the work to date which would cause concern in terms of the four principles against which Council appointments processes are assessed: merit; fairness; transparency and openness, and inspiring confidence.

9. **Resource implications**

9.1 Resources required for the working group will be met from existing budgets.

10. **Risk implications**

10.1 Appropriate and robust processes for Council appointments are essential to maintaining good governance and public confidence in the GPhC.

**Recommendations**

The Council is asked to:

i. note the report of the Council appointments working group;

and agree that:

ii. the person specification for a Council member or Chair of Council, including essential criteria and any desirable criteria, be approved by the Council

iii. an appointments element, covering both Council and associate recruitment, be incorporated in the organisation’s communications work

iv. a mixed approach be taken to promoting diversity among candidates based on: reviewing advertising and publicity; simplifying the application process where possible, and broader community engagement.

*Judy Worthington, Chair, Council Appointments Working Group*

*General Pharmaceutical Council*

*Christine Gray, Registered Pharmacies Rules Lead*

*christine.gray@pharmacyregulation.org*

*Tel 020 3713 7816*

*21 August 2014*
Appendix 1

Terms of Reference
Council Appointments Working Group

1. Purpose
To review the Council recruitment and selection process and make recommendations to the Council on the processes to be used to fill Council vacancies arising in 2016.

2. Membership
2.1 The Group comprises three Council members, one of whom acts as Chair, and an independent member with relevant expertise. The members are:
   - Judy Worthington (Chair)
   - Sarah Brown
   - Tina Funnell
   - Radhika Seth (independent member).
2.2 The Chair shall have a casting vote if necessary.
2.3 The Group shall be able to agree matters by email or teleconference if required.

3. Remit
The Group shall:

3.1 Review the:
   i. process for the Council appointments made in 2014
   ii. governance arrangements for the setting of Council member essential criteria and the experience required across the Council as a whole
   iii. recruitment and selection process for Council appointments
   iv. use of an external search resource
   v. potential for increasing the diversity of applicants
3.2 Develop a process for reappointments to the Council
3.3 Review the appraisal process for Council members and Chair to ensure it is sufficiently meaningful and robust to support a reappointments process
3.4 Make appropriate recommendations to the Council.

4. Timescale
4.1 The Group shall complete its work by February 2015.

Effective date: 10 April 2014
Agreed by: GPhC Council
Developing the draft continuing fitness to practise framework

Purpose
To outline and gain approval for a revised delivery plan and a proposal for an advisory group for development of the draft continuing fitness to practise (CFtP) framework.

Recommendations
The Council is asked to agree:

- the revised delivery plan summarised in appendix one; and
- the establishment of the proposed CFtP Advisory Group summarised in appendix two.

1. Introduction
1.1 The Council, at its meeting on 14 November 2013, agreed:
   
   i. to develop a draft framework for CFtP;
   ii. to review the current CPD ‘Call and Review’ process; and
   iii. a timetable for the development and review activities.

1.2 Since that meeting, components of development work have taken place, such as:
   
   i. early engagement with key stakeholder bodies;
   ii. initial research and scoping for the review of current CPD processes;
   iii. collaboration with Department of Health on the underpinning legislation; and
   iv. the appointment of a Head of Continuing Fitness to Practise to lead the development.
1.3 Owing to a number of factors, revisions to the agreed timetable are required. The overall deadline remains the same but the phasing of activities has changed.

1.4 This paper presents a summary of the key activities required for the development of the draft CFtP framework and the broad timescales for them (summarised in appendix one).

1.5 The paper also presents a proposal to establish the Continuing Fitness to Practise Advisory Group (summarised in appendix two).

2. Establishing governance arrangements

2.1 The Council will make final decisions on the CFtP framework and its implementation.

2.2 The Executive Team will steer and authorise the programme of development on the Council’s behalf.

2.3 A CFtP Programme Team, led by the Head of Continuing Fitness to Practise and made up of GPhC employees will undertake the development activities and report to the Executive Team and Council.

2.4 A CFtP Advisory Group made up of a broad representation of stakeholders will advise the Programme Team and provide assurance to the Council on the development activities.

2.5 Terms of reference for the CFtP Advisory Group will be agreed at the first meeting using the proposal in appendix two of this paper as a guide. Council’s views on the proposal for how the group will work are welcomed. The terms of reference will be brought back to Council for approval.

3. Research and testing

3.1 The bulk of the early stages of the programme will be made up of research and testing. The scope of research and testing will be influenced by stakeholders (including internal stakeholders) over the course of the 2014/15 financial year. Paragraphs 3.2 and 3.3 outline the current research and test needs that have been identified.

3.2 Key research activities include:

i. Expert surveys to explore the consensus around the purpose, outcomes and proposed methods of CFtP.

ii. A review of the CPD ‘Call and Review’ process.

iii. Basic research into the availability and accessibility of performance indicators for pharmacy professionals.

iv. Basic research into the organisations currently providing peer review services and how they operate.
3.3 Development of the draft CFtP framework will include testing of:
   i. CPD standards, framework, rules and outcomes measures for suitability for CFtP.
   ii. risk model options (including risk based sampling for audit).
   iii. peer review options.
   iv. partner organisation accreditation model options.
   v. scenarios for registrants:
      • working in atypical contexts and settings (for example: overseas, lone practice, non-clinical roles)
      • with additional needs requiring reasonable adjustments.
      • subject to fitness to practise allegations or employer disciplinary processes.
      • with peer reviewers subject to fitness to practise allegations or employer disciplinary processes.
      • working in a premises which have failed to meet the pharmacy standards.
   vi. decision-making protocols for CFtP for registrants, peer reviewers and GPhC.
   vii. risk intelligence handling of information from within GPhC across functions (for example: CFtP, FtP, education, premises inspection).
   viii. risk intelligence handling of information from outside of GPhC.

4. Piloting

4.1 Piloting will take place after evaluation of the research and testing phase. The pilots will be deeper investigations into the draft framework’s operation and effectiveness. There will be fewer pilot sites than test sites therefore, but there will still be an appropriate range of settings and contexts of practice across Great Britain.

5. Communications and Engagement

5.1 Communications and engagement activities, which use the organisational communication strategy as a base, underpin the development of the draft framework and comprise the following activities:
   i. Internal communications and preparation for the potential changes to processes and systems.
   ii. Thought leadership, consultative engagement and information sharing with external stakeholders through events, speaking
developments, webinars and published materials in trade press, Regulate and on the GPhC website.

iii. Social media engagement including crowd sourcing on specific areas of consultation.

iv. Sharing and ‘work-shopping’ of draft components of the framework through established GPhC ‘Sounding Boards’ and other networks developed by stakeholder organisations.

v. Public consultation following evaluation of piloting.

5.2 Communications and engagement activities will aim to reach the a wide group involved with pharmacy across England, Scotland and Wales, including patients and the public, registrants, employers, commissioners and training providers.

6. Equality and diversity implications

6.1 The development of the draft framework will evaluate equality and diversity impact throughout testing, piloting and implementation using the organisational approach to equality impact analysis as a basis.

7. Resource implications

7.1 Detailed work planning is currently taking place and will be fed into the corporate business planning processes to agree a budget and resource allocation for 2015/16.

7.2 As much as possible, human resources will be deployed across relevant existing functions of the business rather than in new structures.

7.3 There will however, be a resource need in the Continuing Fitness to Practise Team for co-ordination of activities and provision of specialist expertise. Resource planning will be taken forward into 2015 to 2018 business planning and a business case for a small increase in human resources in 2014/15 will be presented to the Executive Team for consideration in September 2014.

7.4 Long term resource impacts will be evaluated through testing, piloting and implementation.

8. Risk implications

8.1 A risk register for the development of the framework has been produced which feeds into directorate and organisational risk registers so that the Council through the Audit and Risk Committee can monitor risks associated with the development of the framework.

8.2 The risks emerging from the work are typical of the risks from the development of new regulatory measures and include routine mitigations
such as developing sound governance, extensive engagement activities, and thorough impact assessment of proposals prior to implementation.

Recommendations

The Council is asked to agree:

- the revised delivery plan summarised in appendix one; and
- the establishment of the CFtP Advisory Group summarised in appendix two.

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General Pharmaceutical Council
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Tel 0203 713 7962
27 August 2014
### Draft CFtP framework development plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time frame</th>
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</thead>
<tbody>
<tr>
<td>Communications and engagement activities</td>
<td>2014-2018</td>
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<tr>
<td>Establishment of governance structures</td>
<td>July 2014 to December 2014</td>
</tr>
<tr>
<td>Preparing and undertaking CPD review</td>
<td>August 2014 to March 2015</td>
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<tr>
<td>Preparing tests</td>
<td>August 2014 to March 2015</td>
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<tr>
<td>Undertaking tests</td>
<td>Q1-3 2015/16</td>
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<tr>
<td>Evaluating Tests</td>
<td>Q3 2015/16</td>
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<tr>
<td>Council review of test evaluation and proposals for piloting</td>
<td>Q3 2015/16 (December 2015 Council)</td>
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<tr>
<td>Preparing pilots</td>
<td>Q3-4 2015/16</td>
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<tr>
<td>Undertaking pilots</td>
<td>Q1-3 2016/17</td>
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<td>Evaluating pilots</td>
<td>Q3-4 2016/17</td>
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<tr>
<td>Council review of pilot evaluation and proposals for draft framework for consultation*</td>
<td>Q3-4 2016/17 (March 2016 Council)</td>
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<tr>
<td>Consultation</td>
<td>Q1 2017/18</td>
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<tr>
<td>Council review of consultation outcomes and proposals for the final framework</td>
<td>Q2 2017/18 (September 2017 Council)</td>
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<tr>
<td>Communication of consultation outcomes</td>
<td>2017/18</td>
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<tr>
<td>Internal and external preparation for implementation</td>
<td>2017/18</td>
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<tr>
<td>Implementation</td>
<td>2018</td>
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**Note:** Quarters are linked to financial years

* Council may wish to make the decision to extend piloting across a wider sample at this time where legal powers allow this. For example, if changes to CPD call and review processes are found to bring additional benefits to registrant engagement with CPD, then a decision could be made to extend the pilot until implementation formalises the new arrangements.
Appendix 2

CFtP Advisory Group

Background

The Council agreed to develop a draft CFtP framework in November 2013. A CFtP advisory group was proposed to provide senior level advice to the executive and assurance to the Council on the development and design of the draft framework.

How it will work - proposal

- The group will be sponsored by the Director of Policy and Communications and supported by the Head of Continuing Fitness to Practise.
- Meeting and engagement formats will be flexible. Formats will include: formal meetings with papers, facilitated explorations of particular topics, online, email or telephone engagement on particular topics.
- Formal meetings will be held twice a year.
- All meetings and engagement with the group will account for no more than a total of six working days for each member of the group.
- The group will operate for one year, with the first formal meeting to be held in December 2014. The Council will review the group’s role and the requirement for future meetings in September 2015.
- This group will be made up of two Council members (one registrant and one lay) and representatives from key external stakeholder organisations including patient and public representative organisations. It is suggested that the Chair of Council will review the Council members on the group at a regular interval to ensure that membership remains current (Council members’ terms may expire during the course of the advisory group) and that fresh perspectives and contributions are made to the group. The proposed interval is two years.
- A core group of 10 members will be invited to attend face to face meetings.
- A wider group of a further 10 members will have corresponding member status and receive papers so that views can be expressed through the Chair. These members will also be invited to input into informal engagement activities.
- The group membership will seek to balance the number of pharmacists and pharmacy technicians.
- Members of Council will express interest to join the Group to the Chair of Council, who will appoint the members to the Group and it is proposed the Chair of Council will name one as Group Chair.
- External bodies from the list below will be asked to nominate representatives and alternates to be members of the Group. The Group Chair will appoint the members based on the nominations.
- Formal meetings will require administrative support from the Governance team for co-ordination, and production and distribution of papers.
• Informal engagement will require document preparation and facilitation from the Continuing Fitness to Practise team with support from other teams in the Policy and Communications directorate on occasion.
• Terms of reference for the CFtP Advisory Group will be agreed at the first meeting using this document as a guide. The terms of reference will be brought back to Council for approval in February 2015.

Functions of the Advisory Group
The group will, using the draft principles underpinning the continuing fitness to practise as a frame, provide advice to the executive and assurance to Council on the development programme for the draft continuing fitness to practise framework, including:

1. The proposed methodologies for assuring continuing fitness to practise through to CPD, peer review and performance indicators.
2. The suitability of the range and scope of testing and piloting of the elements of the framework.
3. The suitability of evaluation criteria and methodology for the tests, pilots and draft framework.
4. The impact assessment methodology and criteria (including cost, and equality and diversity).
5. The communications and engagement strategy to ensure that our policy and operational development take into account the views of patients and users of pharmacy services, as well as registrants and all forms of pharmacy professional employer and commissioner.

Membership of the group
The group will be made up of organisations representing the following groups across Great Britain:

1. Pharmacists and pharmacy technicians
2. Employers across a range contexts and settings of pharmacy practice
3. Patients and the public
4. Training providers (post-registration)

The group may also wish to invite the following types of stakeholders to formal meetings or informal engagement activities:

1. Commissioners
2. Unions
3. Students and trainees
4. Training providers (pre-registration)
5. Other regulators (both professional and systems)
Public business

Establishment of Pharmacy Regulation Development Assurance Group

Purpose
To consider recommendations for the provision of feedback to the Registrar and Executive and assurance to Council on the regulation of pharmacy premises

Recommendations
The Council is asked to

i. Agree that a working group be established with delegated authority to provide feedback to the Executive and assurance to Council on the regulation of pharmacy premises

ii. Agree the process for establishing the working group

2. Introduction

2.1 The GPhC’s development of new standards for registered pharmacies (approved in September 2012) and the implementation of a prototype inspection model (2013/14) have followed distinct and successive phases.

2.2 The next phase is to provide feedback to the Executive and assurance to Council on these areas of development and the wider work on the regulation of pharmacy premises.

3. Pharmacy Regulation Development Assurance Group (PreDAG)

3.1 Given the scale of the work and the importance of Council input, it is proposed to establish a task and finish group, PreDAG, to provide input into this work stream. This will build on the success of the Inspections Development Assurance Group.

3.2 The next phases of work include:
• Learning from the experiences and adapting and improving the policy framework, including a review of the standards underpinning regulation
• Reviewing the evidence and data collected through inspections
• Beginning formal evaluation of both standards implementation/adoption and inspection model; and
• Continuing to learn from others as they develop models of regulation, enforcement and inspection
• Monitoring the interface with Rebalancing programme
• Preparing for changes in the enforcement regime and the publication of inspection reports

3.3 It is proposed that PreDAG will build on the strengths of IDAG which combined presentation style workshop discussion with clear agendas and formal minutes.

3.4 The working group would be jointly sponsored by the director of policy and communications and the director of inspection and fitness to practise.

3.5 This group would be made up of relevant staff and four council members, with an equal lay and registrant mix

3.6 The governance team would provide secretariat support needed.

3.7 Assuming that the recommendations in this paper are accepted, expressions of interests to sit on the task and finish group from Council Members should be directed to the Head of Governance who will collate them on behalf of the Chair. The Chair will then select the four members including the chair for the group, having taken soundings from colleagues.

3.8 It is proposed that the task and finish group will bring its terms of reference to Council for approval in November 14. This would follow its inaugural meeting.

4. **Equality and diversity implications**

4.1 The task and finish group will consider any equality and diversity issues arising from the development work streams.

5. **Communications**

5.1 The membership of the task and finish group will be presented to Council alongside the proposed terms of reference.

6. **Resource implications**

6.1 There are no resource implications arising from this paper.
7. **Risk implications**

7.1 As part of the GPhC’s drive for proactive, good quality regulatory services it needs to ensure that it is constantly reviewing and learning from the developments in the delivery of its functions. Failure to do so could lead to inefficiency and poor outcomes. The task and finish group will be a key part of this process by providing feedback to the Executive and assurance to Council. The work streams in this area relate to a number principal risks in the strategic risk register.

8. **Monitoring and review**

8.1 PreDAG will propose a regular reporting cycle to Council as part of its draft terms of reference. The group will also establish a timeframe for the completion of its work.

**Recommendations**

The Council is asked to

i. Agree that a working group be established with delegated authority to provide feedback to the Executive and assurance to Council on the regulation of pharmacy premises

ii. Agree the process for establishing the working group

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Duncan Rudkin, Chief Executive & Registrar  
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Tel 020 3713 7811  
20 August 2014
Professional Standards Authority performance review report 2013-14

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 2013-14

1.1 The PSA review report for 2013-14, which contains PSA's reports on the performance of the nine health and social care professional regulators, was laid before Parliament on 26 June. The report is available at: http://www.professionalstandards.org.uk/docs/default-source/scrutiny-quality/performance-review-report-2013-2014.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 has concerns about the GPhC’s performance against the sixth Standard of Good Regulation for fitness to practise, which relates to the timely progression of cases through the fitness to practise process. The PSA noted that there had been some improvement at particular stages in the time taken for cases to progress through the fitness to practise process, but they were concerned about the length of time taken for cases to conclude.

1.3 The PSA described the GPhC’s unique position in regulating premises and professionals, noting the ongoing programme of legislative work that is being undertaken with the Department of Health to enable the GPhC to use its full range of regulatory powers. The PSA also noted that premise regulation was not covered by its Standards of Good Regulation and would be considering how to incorporate this aspect in their upcoming process review.
1.4 The PSA commended the GPhC for its initial report on the ethnicity of registrants who are the subject of fitness to practise proceedings and looked forward to following up on progress in this area.

1.5 In the 2012-13 review the PSA was unable to confirm that the GPhC had met the tenth Standard of Good Regulation for fitness to practise, which relates to the secure retention of information about fitness to practise cases. This was due to a data breach which occurred in February 2013. In this year’s report the PSA noted the steps the GPhC has taken to prevent a reoccurrence and the ICO decision not to take any action, having taken these measures into account.

2. Sixth Standard of Good Regulation for fitness to practise

2.1 Whilst the PSA’s overall view is that the GPhC continues to maintain its performance as an effective regulator, the PSA has raised concerns about the sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of both sides. In this year’s review the PSA has found that the GPhC has not met this standard, though it acknowledges that the GPhC has taken steps to improve the timeliness of the progression of its fitness to practise (FtP) cases.

2.2 As Council will be aware, FtP has been the subject of internal review and a number of developments are now in place to improve performance through increased productivity and efficiency.

2.3 This is set in the context of increasing numbers of concerns being received. From June 2013 to June 2014 the GPhC received 1171 cases. This represents an increase of 316 cases or 36% when compared to the same period for 2012-2013. The largest increase in complaints is from the public and one contributing factor to this is the result of the revised online complaints form which has simplified the process of raising a concern. The majority of complaints relate to misconduct (dishonesty and dispensing errors with no or low to moderate harm).

2.4 To provide Council with some assurance about progress with improving performance in FtP, members are asked to note the following:
   
   i. all of the inherited legacy cases have now been closed;
   
   ii. the number of cases aged over 12 months has remained steady despite increases in the number of cases received. Cases that are over 12 months old are being actively managed and monitored to ensure that they are closed as efficiently as possible;
iii. the average age of cases has reduced to 8.69 months, from 15.17 months in 2011, as work continues to review and progress cases over 12 months;

iv. as a result of the implementation of the LEAN review and through investing in the capacity and infrastructure of the FtP teams productivity has increased;

2.5 Overall, in the face of rising numbers of concerns the GPhC has maintained and is improving performance. This is evidenced by the reducing age profile of cases and improving closure rates and productivity. Equality and diversity implications

3. Performance review 2014-15

3.1 The PSA has indicated that it will follow up on a number of issues in the 2014-15 review including:

- Improvements in FtP performance.
- The development of guidance on the supply of P medicines and the supply of medicines over the internet.
- The GPhC’s use of the data obtained from the registrant and stakeholder survey.
- The review of the Standards of Conduct, Ethics and Performance.
- Consultation on the standards for the initial education and training of pharmacists.
- Analysis of assessment performance by ethnicity.
- Changes to the GPhC’s case management system in terms of data capture and the new system itself.
- Data capture on the time between the receipt of adverse information and the imposition of an interim order.
- Consistent compliance with data protection obligations.

3.2 The GPhC continually reviews progress against the commitments made during 2013-14. In addition, there is regular monitoring of progress against those issues which the PSA has indicated that it will want to follow up on in the 2014-15 review.

3.3 The evidence submission template for the 20143-15 review will be sent to regulators on 22 September 2014 for completion by 17 November 2014.

3.4 Council will note that this is this is the last year that the PSA will perform its review in this way. The PSA will be undertaking a review of its standards, process and publication of reports and the Authority will be consulting with
regulators during the autumn of 2014 with a view to putting draft proposals to its Board in January 2015. If accepted, there will be a formal consultation on the proposed changes with a view to them being implemented in summer 2015.

3.5 The PSA has indicated that it is likely to adopt a risk based approach to performance reviews which would mean that a full scale performance review would not necessarily be carried out annually on each regulator.

4. Equality and diversity implications
4.1 There are no equality and diversity implications raised in this paper.

5. Communications
5.1 The publication of the PSA performance review report was promoted on the GPhC website.

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

7. Risk implications
7.1 There are reputational risks for the GPhC if it fails to respond adequately to recommendations made by the PSA. The GPhC has effective monitoring procedures in place to ensure it is keeping track of those recommendations and commitments made in the 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
15 August 2014
Council meeting 11 September 2014

Public business

Chief Executive and Registrar's report

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

Recommendations
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 that they have the most up-to-date supporting material.

2. Annual Report 2013-14

2.1 The GPhC annual report 2013-14 covering the Council’s third full year in operation was published in June. Key achievements for 2013-14 highlighted in the report include:

- Putting the focus on improving pharmacy services by raising awareness of our standards for registered pharmacies and rolling out a new prototype inspection model
- Following the Francis Inquiry and other key reports, we have made sure there is a continued focus on patient care and compassion in pharmacy and we have improved our joint working to share information and communicate with other organisations to share feedback on risks and events appropriately
- Making further improvements in our operational performance, including fitness to practise procedures and our registration processes
- Developing new learning outcomes for the initial education and training of pharmacists
- Improving how equality and diversity are built into the way we operate.

2.2 The report also outlines the GPhC’s plans for this year including:

- Creating a patient hub on our website to help make sure patients are confident in using pharmacy care, to hear their views about what we do, and let patients share their experiences of pharmacy care to help improve it
- Developing the Continuing Fitness to Practise (CFtP) framework for making sure that pharmacists and pharmacy technicians on our register remain fit to practise and to keep patients safe
- Reviewing our standards of conduct, ethics and performance
- Updating our contact centre call handling system as part of the improvements to our IT infrastructure

3. **June 2014 registration assessment**

3.1 There were 2549 candidates who sat the GPhC’s Registration Assessment on 27th June 2014 with 2175 candidates passing the assessment, an 85.3% pass rate. 2377 candidates sat the assessment for the first time, 89 for the second time and 83 for the third time. The list of successful candidates is available on our website.

4. **GPhC fees**

4.1 We have contracted Professor Barry McCormick of Economic Analysis Associates to undertake an independent collection and analysis of data to inform the allocation of expenditure to the GPhC’s registrant groups with a view to advising on future fee setting strategy. Professor McCormick will produce a report summarising advice on direct costs by registrant group and implications for fees based on direct costs of regulation for each group. The report will be available in sufficient time to be taken into account when Council next makes recommendations on its fee setting strategy in February 2015.

4.2 Professor McCormick is Director of the Centre for Health Service Economics and Organisation (CHSEO) based in the departments of Primary Care and Economics at the University of Oxford. He was Chief Economist at the Department of Health and is Professor Emeritus of the University of Southampton. He led the 2011 analysis of regulation costs and efficiency at PSA (then CHRE).
5. **PSA fees**

5.1 In the Health and Social Care Act 2012, the Government outlined its intention to require the regulatory bodies to fund certain functions of the Professional Standards Authority. Following discussions with the Treasury to agree a fee model, the Department of Health has advised that it will be proceeding with a fee model based on a fixed fee per registrant.

5.2 The Department of Health intends to consult on the new fee scheme later this year with a view to it being in place from April 2015.

6. **Memoranda of Understanding update**

6.1 A progress report was submitted to Earl Howe in July. The report set out an early view and a plan for future evaluation of the memoranda of understanding which the GPhC signed in spring 2014, to support the aim of the organisation becoming the principal regulator with responsibility for pharmacy inspections.

6.2 The implementation of the agreed MoUs, including embedding them into organisational practices, is currently underway. For example, a joint implementation project group is being established between the GPhC and NHS England.

6.3 There are already a number of examples of the GPhC working with its partners to address concerns. In April the GPhC carried out an inspection with support by staff from NHS England, MHRA and CQC in response to concerns about an organisation. This was followed up by another inspection in July to monitor progress against an action plan put in place following the first inspection.

7. **Pharmaceutical Society of Northern Ireland**

7.1 The GPhC has renewed its Memorandum of Understanding with the Pharmaceutical Society of Northern Ireland (PSNI). The GPhC and PSNI have had an MoU in operation since 2011.

7.2 The two organisations maintain regular contact and an open exchange of information through both formal and informal meetings at all levels including a formal annual review meeting. The GPhC and PSNI keep each other informed of relevant operational and policy development work, and continue to seek ways in which consistency of standards and mutual recognition can be achieved where possible. The MoU is available [here](#).
8. **Duty of Candour**

8.1 The chief executives of the statutory regulators of healthcare professionals, including the GPhC, are working to agree a joint statement on the professional duty of candour.

8.2 The regulators have agreed to promote the statement to their registrants, students, and to patients, ensuring registrants know what is expected of them. As the GPhC reviews its standards it will strengthen references, where necessary, to being open and honest and encourage registrants to reflect on their own learning and continuing professional development needs regarding the duty of candour.

9. **Improving the advice patients receive about their medicines**

9.1 On 3 July the GPhC and RPS hosted a seminar on improving the advice patients receive about their medicines. The seminar, attended by the Chair and Chief Executive, followed on from a similar event in 2013 prompted by the Which? investigation highlighting the variability in medicines advice provided by community pharmacies across the UK.

9.2 The event, which was attended by a range of industry groups, individual pharmacists, and patient representatives, showcased the progress that had been made in the past year towards improving medicines advice, focusing primarily on improving the skills and training of the whole pharmacy team, including support staff.

9.3 Concluding the event the Chief Executives of the GPhC and RPS launched a joint statement highlighting the importance of regulatory and professional standards and guidance as a way to protect patient safety and to promote responsibility and professionalism.

10. **Vale of Leven Inquiry**

10.1 The Vale of Leven Hospital Inquiry was set up in 2009 by Scottish Ministers to investigate the circumstances contributing to the occurrence and rates of C. difficile infection at the Vale of Leven Hospital in West Dumbartonshire from 1 January 2007 onwards, with particular reference to the circumstances which gave rise to a number of deaths associated with that infection.

10.2 The Inquiry was originally due to report its findings by May 2011 but has been repeatedly delayed due to a number of factors. Latest indications are that the report will be published in autumn 2014.

10.3 The GPhC Director for Scotland will continue to liaise with Scottish Government regarding the report and any potential references to or criticisms of pharmacists or pharmacy services and will identify any actions arising once the report is published. Work will also continue to pursue memoranda of
understanding on information sharing and collaborative working arrangements with Healthcare Improvement Scotland and regional NHS Health Boards.

11. **Rebalancing update**

The Chair and Chief Executive attended the latest meeting of the Rebalancing Programme Board on 30 June. The minutes from this meeting, when published, will be 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)

12. **Consultations**

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

**Recommendations**

The Council is asked to note this paper.

*Duncan Rudkin, Chief Executive and Registrar*  
*General Pharmaceutical Council*

*duncan.rudkin@pharmacyregulation.org*  
*Tel 020 3365 3501*  
*20 August 2014*
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: Nigel Clarke (NC), Duncan Rudkin (DR), Bernard Kelly (BK), Hugh Simpson (HS), Claire Bryce-Smith (CBS):

Chair (Nigel Clarke):

- Association of Pharmacy Technicians (APTUK) - Annual Conference
- Public Policy Projects discussion breakfast - ‘Regulating health and social care professionals…putting patients and the public first’
- National Voices Chairs’ dinner
- Healthcare Regulators’ Chairs’ meeting
- Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board – meeting (with DR)
- General Pharmaceutical Council (GPhC) and Royal Pharmaceutical Society (RPS) joint event - ‘Delivering High Quality Pharmacy Advice’ (with DR, HS and CBS)
- Chair of Health Select Committee - meeting (with DR)
- Royal Pharmaceutical Society (RPS) Annual Conference - speaking (with DR)
- President and Registrar of the Alberta College of Pharmacists - meeting (with DR)

Staff:

- Chief Executive, Royal Pharmaceutical Society (RPS) - update meeting (with DR)
- Senior Head of Patient Safety, NHS England - meeting (DR and HS)
- Chief Pharmaceutical Officer, Head of Primary Care Commissioning, NHS England and Senior Pharmacist, National Patient Safety Agency - meeting (DR, HS and CBS)
- Deputy Head of Professional Standards Branch, Senior Legislation Manager, Department of Health - meeting (DR and HS)
- Chief Executive, Pharmaceutical Society of Northern Ireland (PSNI) - meeting (DR)
- Chief Pharmaceutical Officer for England – update meeting
• Chief Executive, Professional Standards Authority (PSA) - update meeting (DR)

• Department of Health (DH) Professional Standards liaison regular meeting (DR and HS)

• Public Health System Group Stakeholder Forum - launch event (DR)

• Healthcare Regulators Chief Executives’ Legislation Group (DR)

• Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board – meeting (NC and DR)

• Inside Government ‘Understanding the Future Landscape for UK Pharmacies’ forum - speaking (DR)

• General Pharmaceutical Council (GPhC) and Royal Pharmaceutical Society (RPS) joint event ‘Delivering High Quality Pharmacy Advice’ (NC, DR, HS and CBS)

• President, British Pharmaceutical Students’ Association (BPSA) - meeting (DR)

• Legal Services Consumer Panel, ‘Legal Services in 2020’ - event (DR)

• Healthcare Regulators Chief Executives’ Steering Group (DR)

• President, Association of Pharmacy Technicians (APTUK) - meeting (DR)

• Chief Executive, National Pharmacy Association (NPA) - meeting (DR)

• Chief Executive, Professional Standards Authority (PSA), update meeting (DR)

• Chair of Health Select Committee - meeting (DR with NC)

• Royal Pharmaceutical Society (RPS) - Awards Dinner (DR)

• RPS Annual Conference (DR with NC)

• President and Registrar of the Alberta College of Pharmacists, meeting (DR with NC)

• Centre for Analysis of Risk and Regulation (CARR) Regulators’ Forum (CBS)

• Healthcare Regulators Directors of Fitness to Practise (CBS)

• Law Commission Bill, Inter-Regulatory Forum (HS)

• Healthcare Regulators, Department of Health, Regulator Bill policy meeting (HS)

• Principal Pharmacist, Medicines Pharmacy and Industry, Department of Health - meeting (HS)

• Chief Executive, Action against Medical Accidents (AvMa) - meeting (HS)

• Council on Licensure, Enforcement and Regulation (CLEAR) Conference (HS)
### Active and new consultations

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<tr>
<td><strong>A Review of Concerns (Complaints Handling) within NHS Wales</strong></td>
<td>Welsh Government</td>
<td>The Welsh Health Minister has launched an inquiry to review the current arrangements for the management of concerns in the Welsh NHS. The aim is to determine what is working well and what needs to improve. This needs to be considered from the perspective of: patients, their families and carers; staff; NHS organisations; and other stakeholders involved in the process including Community Health Councils and the Public Services Ombudsman for Wales. It will need to include the handling of concerns within primary and community care as well as hospitals. The inquiry will have to consider if there is sufficiently clear leadership, accountability and openness within the process and to identify how the NHS in Wales can learn from other service industries.</td>
<td>Not specified</td>
<td>Responded to by Darren Hughes. Response is available <a href="http://wales.gov.uk/topics/health/publications/health/reports/complaints/?lang=en">here</a>.</td>
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<td><strong>Consultations on CQC guidance to help services meet new regulations</strong></td>
<td>CQC</td>
<td>CQC has issued its draft guidance on how providers can meet the eleven fundamental standards as part of a public consultation. Alongside this, CQC is asking for views on how it will use its strengthened enforcement powers, as set out in the Care Act 2014. These will allow CQC to decide on the most appropriate enforcement action to take when care</td>
<td>17/10/14</td>
<td>Reviewed by Andy Jaeger, Priya Warner and Sarah Jennings. Decision not to respond formally.</td>
<td>It was decided that the GPhC is not best placed to provide a formal response to the consultation. We will, however, contribute to the consultation by providing an informal response by</td>
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<td>Extending the scope of the Electronic Prescription Service</td>
<td>Department of Health</td>
<td>The Committee invites written submissions of evidence to the inquiry in response to: 1) The objectives and effectiveness of the Better Regulation framework  2) Government departments’ regulatory strategies and performance  3) The scope and impacts of regulation</td>
<td>09/10/14</td>
<td>Reviewed by Priya Warner. Decision not to respond.</td>
<td>The GPhC will not be responding as it is not appropriate for us to do so. This is not a topic related to our core functions, nor is it of importance to our strategic priorities. However, it is useful to keep up to date with developments in the area.</td>
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<td>Whistleblowing: prescribed persons reporting requirement</td>
<td>Department of Business, Innovation and Skills (BIS)</td>
<td>The legislation that governs the Nursing and Midwifery Council (NMC) is restricting its ability to effectively carry out some of its duties. Proposed changes to the Nursing and Midwifery Order 2001 will:  - improve handling of Fitness-to-Practise (FtP) cases  - introduce power to review certain FtP decisions  - allow registrants who are not fit to practise, for health or lack of competence reasons, to be removed from the register  - change who sits on registration appeal</td>
<td>30/09/14</td>
<td>Reviewed by Matthew Hayday. Decision to respond.</td>
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| Proposed changes to modernise and reform the adjudication of fitness to practise cases | GMC and PSA [https://www.gov.uk/government/consultations/changing-how-the-gmc-decides-on-doctors-fitness-to-practise](https://www.gov.uk/government/consultations/changing-how-the-gmc-decides-on-doctors-fitness-to-practise) | The GMC and the PSA are seeking views on proposed changes to the way each body carries out its regulatory functions, including:  
- establishing the Medical Practitioners Tribunal Service as a statutory committee of the GMC  
- strengthening adjudication procedures  
- confirming the objectives of the GMC and its fitness to practise functions  
- amending the grounds on which the PSA can refer fitness to practise panel decisions to the higher courts and introducing a new right of appeal for the GMC | 25/09/14 | Reviewed by Jerome Mallon. Decision not to respond. | The GPhC will not be responding as it is not appropriate for us to do so. However, we will keep up to date with developments relating to this consultation. |
The regulator may issue an interim suspension order when there is a concern about a practitioner.  
At the moment, NHS England has to remove practitioners from a performers list if they have been suspended by their professional regulator under an interim order.  
They are consulting on 2 options for change:  
Option A: NHS England may suspend practitioners from the performers list | 25/09/14 | Being reviewed by Priya Warner                  |                                                                  |
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<td>National Care Standards Review</td>
<td>Scottish Government</td>
<td>The National Care Standards were created to help people understand what to expect from services, and services understand the standards they should deliver. There are currently 23 sets of standards covering a wide range of care services, including nurseries and childminders, care homes for older people, housing support services, hospice care and independent hospitals. This consultation sets out a range of human rights-based proposals for developing new standards that improve the quality of care and protect vulnerable people.</td>
<td>17/09/14</td>
<td>Being reviewed by Lynsey Cleland. Decision not to respond.</td>
<td>The GPhC will not be responding as this consultation does not have a direct impact on our strategic priorities. However, it would be useful for us to be aware of and keep up to date with developments in this area.</td>
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| Mental Health Act Code of Practice consultation             | Department of Health         | The Department of Health is seeking views on proposed changes to the Code of Practice: Mental Health Act (1983). The new draft code includes:  
- 5 new guiding principles  
- significantly updated chapter on how to support children and young people, on the use of restraint and seclusion and the use of police powers and places of safety  
- new chapters on the care planning, equality and human rights, links to the Mental Capacity Act and Deprivation of Liberty Safeguards, and support for victims  
The Code protects patients’ rights, informs health practitioners’ decisions and ensures that the | 12/09/14 | Being reviewed by Andy Jaeger, and Priya Warner. | |
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<td>Mental Health Act is followed. The Code guides people who are detained or treated under the Act, their families and carers about care and support available during a crisis, and what to do if it isn’t received. The Code has sometimes been inconsistently applied, misunderstood or ignored. A revised Code will help provide better patient protection and reflects legal changes and healthcare developments since its last revision in 2008.</td>
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<td>Consultations on CQC guidance to help services meet new regulations</td>
<td>CQC <a href="http://www.cqc.org.uk/content/consultations-our-guidance-help-services-meet-new-regulations">http://www.cqc.org.uk/content/consultations-our-guidance-help-services-meet-new-regulations</a></td>
<td>The CQC has drafted guidance on how the 46,000 health and adult social care providers and services that it regulates across England can meet the government’s new regulations on care and what actions it will take when they fail. The new regulations (called “fundamental standards”) are more focused and clear about the care that people should always expect to receive. They were laid before Parliament earlier this month and will come into effect by next April.</td>
<td>05/09/14</td>
<td>Reviewed by Andy Jaeger, Priya Warner and Sarah Jennings. Decision not to respond formally.</td>
<td>We will be responding informally by email. Further engagement might also follow and we</td>
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<td>They include both the new “duty of candour” and the “fit and proper persons” requirements. These will oblige providers to be open and honest when things go wrong and to hold directors to account when care fails people. These two requirements will apply to NHS trusts from October. CQC has issued its draft guidance on how providers can meet the eleven fundamental standards as part of a public consultation. Alongside this, CQC is asking for views on how it will use its strengthened enforcement powers, as set out in the Care Act 2014.</td>
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<td>will keep up to date with developments in this area.</td>
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<td>Whistleblowing policy-consultation</td>
<td>GOsC</td>
<td>The General Osteopathic Council is consulting on a draft policy about how they handle whistleblowing concerns that have been reported to them. The draft policy sets out the sorts of concerns that they are able to consider, the actions that they can take in response to a concern, and the timescales for doing so. The policy also provides references to further sources of advice and information.</td>
<td>01/09/14</td>
<td>Reviewed by Matthew Hayday. <strong>Decision not to respond.</strong></td>
<td>It is not appropriate for the GPhC to respond, due to it being a draft policy consultation by another regulator of health and care professionals. However, we will keep up to date with developments relating to this consultation.</td>
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<tr>
<td>Care of the dying adult: scope consultation</td>
<td>NICE</td>
<td>NICE have been asked to develop a clinical practice guideline on Care of the Dying Adult for use in the NHS in England, Wales and Northern Ireland. The draft scope defines what aspects of care the guideline will cover and to whom it will apply.</td>
<td>29/08/14</td>
<td>Reviewed by Priya Warner. <strong>Decision not to respond.</strong></td>
<td>The GPhC will not be responding as it is not appropriate for us to do so - this consultation relates to clinical guidance. It does not have a direct impact on our strategic</td>
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<td>Code of practice on confidential information</td>
<td>HSCIC <a href="http://systems.hscic.gov.uk/infogov/codes/cop">http://systems.hscic.gov.uk/infogov/codes/cop</a></td>
<td>The Health and Social Care Information Centre (HSCIC) is inviting health and care policymakers, patient groups, researchers, regulators, and anyone concerned about medical confidentiality to provide their views on a new code which aims to ensure that confidential health and adult social care information is properly handled by all organisations. The HSCIC released a Guide to Confidentiality in Health and Social Care in September 2013. The Code of Practice aims to complete the picture by providing good practice guidance to those responsible for setting and meeting organisational policies in this arena</td>
<td>18/08/14</td>
<td>Reviewed by Priya Warner. Decision not to respond.</td>
<td>The GPhC will not be responding to this consultation, as it does not have an impact on our strategic priorities. Whilst it is a topic which affects those we regulate, it is a consultation for professional bodies and pharmacy representatives to respond to.</td>
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<tr>
<td>Future content and approach to data collection for the Welsh Health Survey (WHS) - consultation</td>
<td>Welsh Government <a href="http://wales.gov.uk/docs/statistics/consultation/140521-welsh-health-survey-future-content-consultation-en.pdf">http://wales.gov.uk/docs/statistics/consultation/140521-welsh-health-survey-future-content-consultation-en.pdf</a></td>
<td>The purpose of this consultation is to seek user views on the future content and approach to data collection for the Welsh Health Survey. The survey provides unique information about the health and health-related lifestyles of people living in Wales. The purpose of this consultation is to seek views of Welsh Health Survey users on the future content and approach to data collection for the survey.</td>
<td>13/08/14</td>
<td>Reviewed by Darren Hughes. Decision not to respond.</td>
<td>Not of direct importance to our strategic priorities.</td>
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<tr>
<td>Protecting health and</td>
<td>Department of Health</td>
<td>The government invites comments on proposals to strengthen controls and safeguards on the use of health information and data.</td>
<td>08/08/14</td>
<td>Being reviewed by Andy Jaeger</td>
<td>This does not have an impact on our strategic priorities.</td>
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<td>care information: a consultation on proposals to introduce new regulations</td>
<td><a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323967/Consultation_document.pdf">Link</a></td>
<td>of an individual’s health and care data. The DH propose allowing a number of local organisations to create secure safe havens, that will have access under strong controls to information from peoples’ personal care records which could be used to identify an individual. These safe havens will need to be accredited by the Secretary of State for Health. The Health and Social Care Information Centre will continue to be responsible for holding identifiable data at the national level.</td>
<td></td>
<td>and Matthew Hayday. Decision not to respond.</td>
<td>priorities. Whilst it is a topic which affects those we regulate, it is a consultation for professional bodies and pharmacy representatives to respond to.</td>
</tr>
<tr>
<td>Realising Our Potential: a sustainable future for Health Education England - consultation</td>
<td>Health Education England <a href="http://hee.nhs.uk/about/a-sustainable-future-for-hee-realising-our-potential/">Link</a></td>
<td>Health Education England (HEE) is examining its functions, structures and processes to ensure it is delivering its tasks in the most efficient and effective way possible. HEE has been working with its Local Education and Training Boards (LETBs) on a programme of work, Beyond Transition, to explore how it can ensure a sustainable future for HEE as a Non-Departmental Public Body, allowing it to build on a successful first year and reach its full potential.</td>
<td>04/08/14</td>
<td>Being reviewed by Damian Day. Decision not to respond.</td>
<td>The GPhC is not best placed to respond to this consultation. However, it would be useful for us to be aware of and keep up to date with developments in this area.</td>
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<tr>
<td>Consultation on accreditation in the Key Information Set</td>
<td>Higher Education Funding Council for England (HEFCE) <a href="http://www.hefce.ac.uk/whatwedo/lt/publicinfo/kis/accredit/">Link</a></td>
<td>Information about accreditations granted to undergraduate courses by professional, statutory and regulatory bodies is gathered as part of the Key Information Set (KIS) for publication on the Unistats web-site. In order to support collecting this information in a consistent, structured way, the Higher Education Statistics Agency, with which HEFCE works to deliver the KIS on behalf of the four UK higher education funding bodies, maintains a list of accrediting bodies and</td>
<td>31/07/14</td>
<td>Responded electronically by Damian Day</td>
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<td>Inquiry into Patient-Centred Care in the Twenty-First Century</td>
<td>RCGP <a href="http://www.rcgp.org.uk/policy/rcgp-policy-areas/inquiry-into-patient-centred-care-in-the-21st-century.aspx">http://www.rcgp.org.uk/policy/rcgp-policy-areas/inquiry-into-patient-centred-care-in-the-21st-century.aspx</a></td>
<td>associated statements describing their accreditations. It administers an annual process through which bodies may apply to be added to this list. Applications are considered by a panel with representatives from HEFCE and the Quality Assurance Agency for Higher Education. HEFCE have recently reviewed and made minor changes to the processes and criteria used in the annual application process. They have also sought to develop and document additional processes for maintaining the list of accrediting bodies. They are now seeking views from the sector and accrediting bodies on the appropriateness of the proposed processes and criteria.</td>
<td>16/07/14</td>
<td>Reviewed by Martha Pawluczyk. Decision not to respond.</td>
<td>It would be more appropriate for professional bodies and pharmacy representatives to respond to this consultation</td>
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An independent inquiry has been set up by the Royal College of General Practitioners (RCGP) to look at how the NHS can best provide care for patients at a time of constrained resources, to meet the needs of the rapidly increasing number of patients with multiple long term conditions. The inquiry is to be chaired by Mike Farrar, the former NHS Confederation Chief Executive and former Head of Primary Care at the Department of Health, and will explore how to find cost effective solutions to the medical, social and financial challenges posed by rising levels of multi-morbidity within society. In order to do this, it will assess three key questions: How do models of NHS care need to change to...
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<tr>
<td>Deliver better patient outcomes, as cost effectively as possible, for the growing number of people living with multiple long-term conditions? What does this mean for the way in which NHS resources are deployed across health economies in a financially constrained environment? How can the role of general practice best be developed to support the new models of care required and what policy levers and financial mechanisms should be put in place to deliver these at the scale and pace needed?</td>
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<td>Data sharing for non-economic regulators</td>
<td>Better Regulation Delivery Office, Department for Business, Innovation &amp; Skills <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/306611/14-770-data-sharing-consultation.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/306611/14-770-data-sharing-consultation.pdf</a></td>
<td>This consultation seeks views on non-economic regulators sharing data collected from businesses, to build the evidence to design effective solutions that work for both parties. One aim is to identify the legal, practical and other barriers which prevent or discourage regulators from sharing data.</td>
<td>07/07/14</td>
<td>Reviewed by Andy Jaeger and Matthew Hayday. Decision not to respond.</td>
<td>The proposals only affect organisations covered by the Better Regulation Delivery Office. It is not appropriate for us to respond but we will keep up to date with developments relating to this consultation (a number of the GPhC’s MOU partners are affected by the proposals).</td>
</tr>
<tr>
<td>Consultation on GDC’s Guidance for the Professional</td>
<td>General Dental Council <a href="https://response.questback.com/thegeneraldentalcouncil/yow5lhpla">https://response.questback.com/thegeneraldentalcouncil/yow5lhpla</a></td>
<td>The General Dental Council (GDC) has opened a consultation on draft guidance for its Professional Conduct Committee panels. The aim of the document being consulted upon is to provide guidance to panels considering what</td>
<td>30/06/14</td>
<td>Reviewed by Jerome Mallon. Decision not to respond</td>
<td>It is not appropriate for the GPhC to respond, due to it being draft guidance consultation by another regulator of health and</td>
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<td>Conduct Committee, including Indicative Sanctions Guidance</td>
<td>v/</td>
<td>sanction to impose following a finding that a registrant’s fitness to practise is impaired. The guidance and its appendices are primarily intended to assist the GDC’s Professional Conduct Committee; however it may also be of assistance to the Professional Performance and Health Committees, insofar as it applies.</td>
<td></td>
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<td>care professionals. However, we will keep up to date with developments relating to this consultation.</td>
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<tr>
<td>Review of the Individual Patient Funding Request (IPFR) process in Wales</td>
<td>Welsh Government Report.</td>
<td>The Minister for Health and Social Services commissioned a review of the IPFR process in October 2013. The report found IPFR supports evidence based decision making on accessing medical and non-medical technologies that are not routinely available in Wales. The report also contains a series of recommendations to strengthen the process. The Welsh Government is now seeking comments and views.</td>
<td>25/06/14</td>
<td>Being reviewed by Darren Hughes. Decision not to respond.</td>
<td>It is not of direct importance to our strategic priorities</td>
</tr>
<tr>
<td>Title</td>
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<td>socialcare/white-paper/?lang=en</td>
<td></td>
<td>The proposals cover a range of public health issues, including action to reduce the harms to health caused by smoking, alcohol misuse and obesity. They provide a set of practical actions which, when combined, aim to have a positive impact on health and wellbeing in Wales. The White Paper sets out how the government will take steps to: improve health over the life course through proposals to address the important public health issues of tobacco, alcohol misuse and obesity; build community assets for health through proposals to strengthen the role of Local Health Boards when planning and delivering pharmaceutical services, and to improve provision and access to toilets for public use; and improve the regulation of certain types of procedures such as cosmetic piercing and tattooing.</td>
<td></td>
<td>available here.</td>
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<td>Value based assessment methods consultation document</td>
<td>NICE</td>
<td>In spring 2013, the government announced in its response to the Health Select Committee report into NICE the ‘central role NICE will take in assessing the value of new medicines’. Following this announcement NICE has produced a set of proposals which will be used to create an addendum to the ‘Guide to the methods of Technology Appraisals’. The proposals are based on terms of reference given to NICE by the Department of Health for what is referred to as ‘value based assessment' and are now open for consultation.</td>
<td>20/06/14</td>
<td>Reviewed by Priya Warner. Decision not to respond.</td>
<td>Not of direct relevance.</td>
</tr>
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<td>Title</td>
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| Inquiry into Better Regulation                 | Regulatory Reform Committee http://www.parliame nt.uk/business/committees-a-z/commons-select/regulatory-reform-committee/inquiries/parliament-2010/better-regulation/ | The Committee invites written submissions of evidence to the inquiry in response to the following subject areas:  
  - The objectives and effectiveness of the Better Regulation framework  
  - Government departments' regulatory strategies and performance  
  - The scope and impacts of regulation                                                                                                                                                      | 13/06/14 | Reviewed by Hugh Simpson and Andy Jaeger.    | Decision not to respond.                                                                      |
<p>| What can patients expect from community pharmacy professionals? – Draft charter for consultation | RPS <a href="http://www.rpharms.com/vx/exchange-sites/RPS/946/new-s-story-downloads/consultation---medicines-charter-for-patients.pdf">http://www.rpharms.com/vx/exchange-sites/RPS/946/new-s-story-downloads/consultation---medicines-charter-for-patients.pdf</a> | The Royal Pharmaceutical Society (RPS) has produced the first draft of its community focused medicines charter for patients. It has been co-produced with patients, patient groups and the public and includes a list of expectations that can be used by patients and the public to know what they can expect from their community pharmacy professionals. The expectations can also be used to help other healthcare professionals to see how community pharmacists can contribute to integrated delivery of care in the community. | 09/06/14 | Reviewed by Priya Warner, Hugh Simpson and Catherine Ryan. | Decision not to respond formally.                                      |
| Call For Evidence - ACMD Diversion &amp; Illicit Supply of Medicines Inquiry | Advisory Council on Misuse of Drugs (ACMD) &lt;request via letter&gt; | The ACMD set up its Diversion &amp; Illicit Supply of Medicines Inquiry in early 2014. A review was commissioned by the Home Secretary after noting that the Inter-Ministerial Group on Drugs and the Home Affairs Select Committee both recognise that medicines are becoming more widely available for misuse through diversion and                                                                                                                                 | 06/06/14 | Reviewed by Priya Warner. Responded to by Ambrose Paschalides. | Response is available <a href="#">here</a>. |</p>
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<tr>
<td>Assisted Suicide (Scotland) Bill - Call for written evidence</td>
<td>Scottish Parliament <a href="http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/74417.aspx">http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/74417.aspx</a></td>
<td>A call for views on the legalisation of assisted suicide has been published by the Scottish Parliament’s Health and Sport Committee, as the parliamentary scrutiny process begins for the Assisted Suicide (Scotland) Bill. The proposed legislation would provide a means for certain people with a terminal or life-shortening illness to seek assistance to end their lives at a time of their own choosing. It would provide protection against criminal and civil liability for those providing such assistance.</td>
<td>06/06/14</td>
<td>Responded to by Lynsey Cleland. Response is available here.</td>
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| Consultation on how we regulate, inspect and rate services | CQC http://www.cqc.org.uk/public/get-involved/consultations/consultation-how-we-regulate-inspect-and-rate-services | The consultation is on the detailed guidance on how CQC will regulate, inspect and rate NHS acute hospitals, mental health services, community health services, GP practices, out of hours services, care homes; home care services; and hospice services. CQC is seeking views on a range of issues about the new approach including:  
• The proposals for a rating system  
• CQC’s view of what a service looks like for any of the rating categories – outstanding, good, requires improvement, inadequate  
• The questions inspectors need to ask to determine if a service is safe, effective, | 04/06/14 | Reviewed by Andy Jaeger and Mark Voce. Decision not to respond formally. | We will keep up to date with developments relating to this consultation. We are engaging with CQC to ensure that we share experiences around inspection. |
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<tr>
<td>Consulting on introducing the European Professional Card (EPC) for nurses, doctors, pharmacists, physiotherapists, engineers, mountain guides &amp;</td>
<td>European Commission</td>
<td>The European Professional Card (EPC) is a key element of Directive 2005/36/EC on the recognition of professional qualifications, as amended by Directive 2013/55/EU. The amending directive took effect on 17 January 2014, and the EU countries are expected to implement it by 18 January 2016. The point of the EPC is to make it easier for professional qualifications to be recognised and for members of a regulated profession to practise elsewhere in the EU. This will be achieved by involving the relevant authorities in professionals' home countries more, and through electronic procedures. The objective of the consultation is to seek further views and collect data on issues including the</td>
<td>02/06/14</td>
<td>Responded to by Martha Pawluczyk. Response is available <a href="http://ec.europa.eu/eusurvey/runner/EPCSurvey2014competentauthorities">here</a>.</td>
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<td>real estate agents</td>
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<td>mobility of professionals, application procedures &amp; fees from the professional associations &amp; the authorities responsible for recognition of professional qualifications in the EU countries. The Commission will use the responses to assess whether the EPC is appropriate for the professions concerned, and what impact it will have on EU countries.</td>
<td></td>
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<td>European Professional Card: Possible Impact on Administrative Costs (to competent authorities, other interested public authorities) consultation</td>
<td>European Commission <a href="http://ec.europa.eu/eusurvey/runner/EP">http://ec.europa.eu/eusurvey/runner/EP</a> Cdata2014</td>
<td>The European Commission has launched a data collection exercise addressed to the competent authorities dealing with the recognition of professional qualifications of the 7 professions pre-selected for further assessment (nurses, doctors, pharmacists, physiotherapists, engineers, mountain guides and real estate agents) concerning possible impact of the European Professional Card (EPC) on their administrative costs. The objective of this exercise is to collect data on the current administrative costs related to the recognition of professional qualifications and the estimates for possible cost implication of the EPC procedure.</td>
<td>02/06/14</td>
<td>Responded to by Martha Pawluczyk. Response is available here.</td>
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Public business

Unconfirmed minutes of the Audit and Risk Committee, 24 July 2014

Recommendations
The Council is asked to note the minutes of the Audit and Risk Committee.
Minutes of the Audit and Risk Committee meeting held on 24 July 2014 at 129 Lambeth Road, London, at 2:00pm

Present
David Prince – Chair
Judy Worthington
Soraya Dhillon
Hilary Daniels

Apologies
Mohammed Hussain
Jenny Brown (Grant Thornton)
Tom Davies (Grant Thornton)

In attendance
Duncan Rudkin (Chief Executive and Registrar)
Bernard Kelly (Director of Resources and Customer Services)
Matthew Hayday (Head of Governance)
Paula Woodward (Council Secretary)
Joe Hall (Head of Finance)
Bill Mitchell (Moore Stephens)
Sarah Hillary (Moore Stephens)

Observer
Hugh Simpson (Director of Policy and Communications)

Public business

19. Attendance and Introductory Remarks
19.1. The Chair welcomed everyone to the meeting. Apologies were received from Mohammed Hussain.
19.2. The Chair reported that as Jenny Brown and Tom Davies were unable to attend the meeting, the GAAP item would be added to the agenda for the October meeting.

20. Declarations of Interest
20.1. There were no declarations of interest.
21. MINUTES OF THE PREVIOUS MEETING
21.1. The minutes of the meeting held on 28 May 2014 were agreed as a true record.
21.2. The minutes of the confidential part of the meeting are held separately.

22. ACTIONS AND MATTERS ARISING
22.1. In relation to the office relocation (minute 7) Bernard Kelly (BK) provided an update on the preparations to date and assured the committee that the move was still expected to take place on the planned dates.
22.2. In relation to the recruitment of a head of finance, BK reported that this would begin again in September.
22.3. The Committee noted that the remaining actions would be covered by items on the agenda or were scheduled for future meetings.

23. INTERNAL AUDIT CHARTER
23.1. Sarah Hillary (SH) of Moore Stephens (MS) introduced the charter and drew members’ attention to the key points.
23.2. The committee discussed the charter and particularly welcomed the explicit reference to the Chief Executive as the ultimate customer of internal audit.
23.3. ACTION: MS and Matthew Hayday (MH) to amend paragraph 6.1 to better reflect the committee’s terms of reference in relation to access to the internal auditors.
23.4. ACTION: MH to propose new IA performance measures for approval by the Executive and review by the committee.
23.5. The committee approved the internal audit charter subject to an amendment to better reflect the committee’s terms of reference.

24. INTERNAL AUDIT STRATEGY AND PLAN
24.1. Bill Mitchell (BM) of Moore Stephens outlined the approach that had been taken to develop the strategy. He reported that the drawing up of an ‘assurance map’ would help the committee and the executive see the strengths and weaknesses of the current assurance framework, and would in turn help with the planning of future internal audit programmes.
24.2. The committee discussed the strategy and welcomed the proposal to involve internal auditors as a sounding board at various planning, implementation and review stages of the organisation’s projects, rather than limiting their work to the more traditional internal audit post – implementation examination, which would nevertheless still take place within the plan..
24.3. The committee noted that the recommendations from previous internal audits would continue to be monitored by Moore Stephens, with the executive expected to report on progress as part of a regular report to the committee.
24.4. In relation to the internal audit strategy:
   i. ACTION: MS/MH to add a fourth bullet under para 3.2 to clearly state the role of Council and the Audit and Risk Committee in relation to identification for new areas for internal audit to review.
   ii. ACTION: MS/MH to add wording to ensure that any slippage is reported including the reasons for such slippage (para 7.1).
   iii. ACTION: MS/MH to change wording of the paragraphs under 9 to ensure that the involvement of the internal auditors is as a sounding board only, with clear terms of reference in each case.

24.5. In relation to the audit plans, the committee discussed the plans and made a number of suggestions:
   i. ACTION: MS/MH to consider how to cover a review of whistleblowing arrangements given the previous audit was in 2011/12
   ii. ACTION: MS/MH to ensure that the remit of the FtP end to end audit was appropriate and to consider whether the audit can be brought forward.
   iii. ACTION: MS/MH to consider whether an internal audit of core financial controls is required in 2016-17.

24.6. The committee approved the internal audit strategy subject to a number of small amendments for clarity.

24.7. The committee approved the internal audit plan for 2014-15 subject to the changes outlined in the actions above, and approved the draft plans for years 2015-16 and 2016-17.

24.8. The committee noted that the following would be prepared for the next meeting in October:
   i. assurance map
   ii. report on implementation of previous IA recommendations and management responses.

25. **UPDATE: INFORMATION GOVERNANCE FRAMEWORK**

25.1. Matthew Hayday (MH) informed the committee that a governance and assurance officer had been appointed and that she had started work to co-ordinate the organisation’s various information governance responsibilities.

25.2. He also reported that an audit by an ISO27001 accreditor was planned for December, with the findings reported to the committee in due course, and that an information governance assurance review would be presented for discussion at the committee’s October meeting.

25.3. He reminded the committee that the organisation continued to align itself with the requirements of ISO27001, but had not yet made a decision to apply for full accreditation. The audit findings would help to inform that decision. The
committee would be kept informed of developments in information governance including information security and the decision about ISO27001.

25.4. The Committee noted the update on the information governance framework.

26. REVIEW OF COMMITTEE TERMS OF REFERENCE

26.1. Matthew Hayday (MH) informed the committee that the scheme of delegation and standing orders has been reviewed by Council at its meeting in June.

26.2. The committee reviewed its terms of reference and noted that no changes were required.

27. COMMITTEE BUSINESS SCHEDULE

27.1. The committee noted that the assurance review items for the next two meetings would be as follows:

   i. 15 October 2014
      - IT Projects
      - Information governance

   ii. 22 January 2015
       - Impact of legislation
       - Break even planning 2016/17

27.2. ACTION: PW to move the review of effectiveness of internal audit from the October 2014 meeting to July 2015.

27.3. ACTION: Assurance reviews: papers to be presented in advance so that committee members can submit questions in good time before the meeting in order to aid the discussion.

27.4. The Council noted the committee business schedule and the dates for committee meetings in 2015.

28. ANY OTHER BUSINESS

28.1. There was no further business.

29. CONFIDENTIAL SESSION – CONFIDENTIAL MINUTES OF PREVIOUS MEETING AND REVIEW OF STRATEGIC RISKS

29.1. The Chair confirmed that the meeting was moving into confidential business. The minutes of this part of the meeting are held separately.

DATE OF NEXT MEETING

Wednesday 15 October 2014 (starts at 9:30am)
Public business

Policy and Procedure Reviews

Purpose
To seek Council’s approval for the policies within its remit that have been recently reviewed

Recommendations
The Council is asked to:

i. Approve the proposed amendments to the Suspension and Removal Procedure for Statutory Committee members, Behavioural Framework for Council Members and Register of Interests

ii. Approve the deferral of the review of and the extension of the currency of the Fees Policy, Raising Concerns and Minimum training requirements for dispensing/pharmacy assistants & medicines counter assistants

iii. Approve the threshold criteria policy and return to registration policy with no amendments

1. Introduction

1.1 Authority in a number of policy areas is reserved to Council within the Scheme of Delegation. This paper presents the review of some of those policies and asks for Council’s approval for either any amendments or for extending the current version where either no changes are required or there is a request to delay the review.

2. Suspension and Removal Procedure for Statutory Committee members

2.1 There is one proposed amendment to this procedure (see Appendix 1).
2.2 The amendment has been made to allow for the scenario where the Registrar disagrees with the proposed initial course of action in respect of an allegation. In this circumstance the decision would be escalated to the Chair of Council. This proposed amendment has been agreed with the Chair of the Appointments Committee.

3. **Fees Policy**

3.1 Council is requested to defer the review of this policy and extend its currency until February 2015. This will enable the outcome of the economic analysis work currently being undertaken on the cost of regulating registrants and registered premises to inform the policy review.

4. **Behavioural Framework for Council members**

4.1 There is one proposed amendment to this policy.

4.2 The policy has been amended to reflect the focus on individual responsibility and accountability as described in *Standards Matter*.

5. **Raising Concerns**

5.1 Council is requested to defer the review of this policy and extend its currency until February 2015. The GPhC has engaged Public Concern at Work, the whistleblowing charity, to conduct a review of its arrangements for raising concerns, initially internally and subsequently for our guidance to the registrants and the public.

6. **Threshold Criteria Policy**

6.1 There are no proposed amendments to this policy. It is published on the website here:

   [http://www.pharmacyregulation.org/sites/default/files/The%20threshold%20criteria.pdf](http://www.pharmacyregulation.org/sites/default/files/The%20threshold%20criteria.pdf)

6.2 An internal review of the threshold criteria policy took place between April and August and involved colleagues across fitness to practise, inspections and policy. This included establishing a review group and holding a workshop.

6.3 The review included looking at the outcomes of the Professional Standards Authority (PSA) initial stages audit in 2012, which includes an audit of our decisions to close cases in line with the threshold criteria policy.

6.4 The review reflected on the way in which the policy has been used to date, how it has informed decision making and the extent to which it has enabled the GPhC to deal with concerns fairly and proportionately. The review sought to ensure that the policy remains fit for purpose.
6.5 The review highlighted the effectiveness of the current policy, it showed that it assisted staff in making decisions for disposal at the earliest, safest opportunity and provided a framework ensuring the appropriate cases were referred to the Investigating Committee.

6.6 It reflects the needs of the existing Fitness to Practise environment and that it was to its advantage that they were linked to GPhC standards with which all pharmacy professionals must comply with.

6.7 No short term changes to the policy were identified. The feedback received was unanimous in stating the policy functioned quite well on the whole and that it was fit for purpose. The confidence it gave staff in making decisions was also highlighted.

6.8 The PSA audit highlighted no issues and stated that closure decisions were taken appropriately in all the cases they audited.

6.9 The Threshold criteria policy is based on the seven principles of the standards of conduct, ethics and performance. The Council has confirmed its intention to initiate a review of the core standards in 2014/15. Therefore the threshold criteria policy will be subject to a substantive review in line with the standards development and review programme.

7. Minimum training requirements for dispensing/pharmacy assistants & medicines counter assistants

7.1 Council is requested to defer the review of this policy and extend its currency until March 2015.

7.2 The policy is currently under review and the education team are collaborating with the fitness to practise policy manager on the issue of registrants working whilst suspended or removed from the register. The revised policy will come to a Council meeting for approval early in 2015.

8. Return to Registration Policy

8.1 There are no proposed changes to this policy.

8.2 The policy remains current and is still felt appropriate for those returning to practise, having been off the register for more than one year, to demonstrate their fitness to practise in respect of maintaining the currency of knowledge and understanding of changes to pharmacy practise appropriate to their intended role, as a pharmacist or pharmacy technician. Portfolios of evidence are assessed by trained external assessors who make a recommendation to the Registrar based upon the evidence provided by the applicant, in line with comprehensive guidelines. The policy remains an effective method for protecting the public.
9. **Register of Interests**

9.1 The policy has been updated to include the requirement for declarations of interest from senior staff as well as Council members following a decision by the registrar (see Appendix 2).

10. **Equality and diversity implications**

10.1 Equality and diversity implications are considered in the development of individual policies.

11. **Communications**

11.1 The revised policies will be placed on the GPhC's intranet and, if they are external facing, on the website.

12. **Resource implications**

12.1 There are no resource implications arising from this paper.

13. **Risk implications**

13.1 Without clearly defined policies and procedures decisions taken by the GPhC may be subject to challenge.

14. **Monitoring and review**

14.1 Each policy has a review date at which point the effectiveness of the policy is reviewed as well as its currency with relevant guidance and best practice. Policies are reviewed earlier if there are changes in legislation which need to be reflected.

**Recommendations**

The Council is asked to:

i. Approve the proposed amendments to the Suspension and Removal Procedure for Statutory Committee members, Behavioural Framework for Council Members and Register of Interests

ii. Approve the deferral of the review of and the extension of the currency of the Fees Policy, Raising Concerns and Minimum training requirements for dispensing/pharmacy assistants & medicines counter assistants

iii. Approve the threshold criteria policy and return to registration policy with no amendments
Matthew Hayday, Head of Governance  
General Pharmaceutical Council  
matthew.hayday@pharmacyregulation.org  
Tel 020 3713 7809  
20 August 2014
Appendix 1

Suspension and Removal Procedure for Statutory Committee members – proposed amendments

4. Procedure for suspension and removal

4.1 Initial action in respect of an allegation(s)

On receipt of an allegation(s) against a member of the committee (or a person on the reserve list), the chair of the Appointments Committee shall, in conjunction with the Head of Organisational Development and People Strategy, consider the matter and decide on the appropriate course of action. This may include:

- Dismissing the allegation/complaint(s) and directing that no further action is required;
- Formally offering advice or a warning to the member or reservist about their future conduct;
- Referring the matter for investigation by the Registrar (or his appointee) and considering (in the case of members) whether in all of the circumstances of the case suspension should be considered by the Appointments Committee.

If the initial action in the respect of an allegation cannot be agreed by the Appointments Committee and the Registrar then it should be escalated to the Chair of Council to determine how matters should proceed.

...

Behavioural Framework for Council Members – proposed amendments

...

Good Personal behaviour

B.1 I will model in my own behaviour the GPhC’s commitment to equality, diversity and inclusion.

B.2 I will display a high level of probity, integrity, objectivity and fairness in my work with the GPhC and will be accountable and responsible for my own behaviour and actions
1. Introduction

1.1 The Council recognises that the management of potential conflicts of interest is an essential component of good governance. The Council has agreed that Council members and senior staff (Chief Executive & Registrar, the Directors, Head of Organisational Development and People Strategy and Head of Governance) be required to register relevant interests and to declare such interests when appropriate so that those conducting business are aware of them.

2. Purpose of policy

2.1 This policy is designed to give guidance on what interests should be declared by Council members and senior staff relating to them, their family members or their close associates that could influence, or be seen to influence, their objectivity when making decisions on behalf of the GPhC. Members and senior staff must also declare any paid employment or relevant voluntary activity. Members and senior staff should err on the side of caution and declare any interests if they are unsure of their relevance.

3. Policy statement

3.1 Guidance for Council members and senior staff on the declaration of interests is set out below. You should declare any interests, financial or otherwise, that you, your family or friends have that could influence, or be seen to influence, decisions that you may take on behalf of the GPhC. If you are in any doubt as to whether or not something represents an interest, you should declare it. You should also declare any activity for which you are paid whether or not the activity relates to the GPhC.

Pecuniary interests – direct
This should include but is not restricted to:

- Any activity for which you are paid, whether or not the activity relates to matters concerning the GPhC, such as:
  - full time or part-time employment of any kind, including paid directorships
  - paid offices held
  - self-employment, such as freelance, contract or consultancy work
  - sponsorship, awards, bursaries, research grants etc.

- Ownership of any company, business or consultancy
- Direct beneficial interests or shareholdings in companies or other bodies that could be perceived as relevant to the GPhC (on your own behalf or on behalf of a spouse or infant children
Pecuniary interests – indirect and relating closely to GPhC activity
Please list all indirect pecuniary interests arising from connections with bodies which have a direct financial interest in matters concerning the GPhC or from being a business partner of, or being employed by, a person with such an interest.

Non-pecuniary interests
Please list all non-pecuniary interests that relate to unpaid office in, membership of or involvement in organisations, associations or other bodies which are regulated in any way by the GPhC or whose activities could be perceived as relevant to the GPhC.

Close family interests
Please list all financial and non-financial interests of close family members and persons living in the same household as the board member that could be thought of as relevant to GPhC activity. Close family members include personal partners, parents, children (adult and minor), brothers, sisters and the personal partners of any of these.

4. Application of policy
4.1 Every six months Council members and senior staff will be sent a blank declaration form asking them to update their declaration of interests by completing the blank form including sending in a nil return if appropriate. Council members’ and senior staff interests are published on the GPhC website.

5. Measurement and evaluation
5.1 In March and September each year the finance team will reconcile the Council member and senior staff declarations against the prior six months’ purchases to check if there have been any related party transactions. This is then reported to the external auditors as part of the year end processes.

Matthew Hayday, Head of Governance
Reference:
Effective date:
Review date:
Agreed by:
Council meeting 11 September 2014

Confidential items