Meeting of Council  
Thursday, 10 November 2016  
1pm to 4pm  
Council Room 1, 25 Canada Square, London E14 5LQ

**Agenda**

<table>
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<td>1. Attendance and introductory remarks</td>
<td>Nigel Clarke</td>
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<td>2. Declarations of interest</td>
<td>All</td>
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<td>3. Minutes of last meeting</td>
<td>Nigel Clarke</td>
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<td>4. Actions and matters arising</td>
<td>Nigel Clarke</td>
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<td>5. Registration Assessment and Board of Assessors' Report – June and September</td>
<td>16.11.C.01</td>
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<td>6. Consultation on standards for the initial education and training of pharmacy</td>
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<td>16.11.C.03</td>
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<td>8. Recruitment of the Appointments Committee Chair</td>
<td>16.11.C.04</td>
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<td>9. Chief executive &amp; registrar’s report</td>
<td>16.11.C.05</td>
</tr>
<tr>
<td>11. Remuneration Committee unconfirmed minutes of 29 September 2016 meeting</td>
<td>16.11.C.07</td>
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</tbody>
</table>

*Public items*

*For noting*

*For approval*
12. Audit & Risk Committee unconfirmed minutes of 26 October 2016 meeting
   For noting
   David Prince

13. Any other public business
   Nigel Clarke

Confidential business

14. Minutes of last meeting
   Confidential session 13 October 2016
   Nigel Clarke

15. Actions and matters arising
   Nigel Clarke

16. Remuneration Committee unconfirmed minutes of 29 September 2016 confidential meeting
   For noting
   Liz Kay

17. Audit & Risk Committee unconfirmed minutes of 26 October 2016 confidential meeting
   For noting
   David Prince

18. Any other confidential business
   Nigel Clarke

Date of next meeting
Thursday, 08 December 2016
Minutes of the Council meeting held on Thursday, 13 October 2016 at 25 Canada Square, London at 2pm

TO BE CONFIRMED 10 NOVEMBER 2016

Minutes of the public session

Present
Nigel Clarke (Chair) Joanne Kember
Sarah Brown Alan Kershaw
Mary Elford Evelyn McPhail
Digby Emson Arun Midha
Mark Hammond Berwyn Owen
Mohammed Hussain David Prince
Liz Kay Samantha Quaye

Apologies
None

In attendance
Duncan Rudkin (Chief Executive & Registrar)
Claire Bryce-Smith (Director of Inspection and Fitness to Practise)
Matthew Hayday (Head of Governance)
Vivienne Murch (Director of Organisational Development and Equality, Diversity & Inclusion)
Hugh Simpson (Director of Strategy)
Lyn Wibberley (Chief of Staff)
Sue Reed (Council Secretary)

67. ATTENDANCE AND INTRODUCTORY REMARKS
67.1. The chair welcomed all present to the meeting.

68. DECLARATIONS OF INTEREST
68.1. The following interests were declared:
   - Item 6 Standards for pharmacy professionals
     All registrant members
69. **MINUTES OF LAST MEETING**

69.1. Reference minute 49.2: to be amended to read “…greater detail in terms of structure and procedure would emerge as the approach developed, and the GPhC’s EDI Manager would oversee this *procedure* development…”.

**ACTION: SR**

69.2. Reference minute 54.2: as written was factually incorrect and a revised form of wording would be agreed by the Chair.

**ACTION: SR**

69.3. The minutes of the public session of the meeting held on 8 September 2016 were confirmed as a fair and accurate record subject to the amendments detailed at 69.1 and 69.2 above.

70. **ACTIONS AND MATTERS ARISING**

70.1. Reference minute 52.2: it was noted that the phrase ‘in a country where English is first and native language’ had been replaced with ‘in a majority English-speaking country’.

70.2. Council noted that there were no other outstanding actions or matters arising.

71. **STRATEGIC PLAN 2017–20**

71.1. Hugh Simpson (HS) introduced 16.10.C.01 which asked Council to agree the draft strategic plan (2017–20).

71.2. Council agreed the draft strategic plan (2017–20) and commended the team on their excellent work.

72. **STANDARDS FOR PHARMACY PROFESSIONALS**

72.1. HS introduced 16.10.C.02 which sought Council’s approval of the standards for pharmacy professionals.

72.2. In the ensuing discussion, Council discussed a small number of drafting amendments.

72.3. Council:

(i) agreed the standards for pharmacy professionals (Annex A)

(ii) agreed the proposal to consult on wording set out in paragraph 3.4 alongside the consultation on guidance on managing personal values and beliefs

(iii) agreed the date for the standards to come into effect (part 4 of this paper)

(iv) noted the equality impact assessment (Annex B)
(v) delegated authority to the Chair of Council to sign off the standards, with the proviso that any substantial changes to wording be circulated to Council for their agreement before sign off

73. GUIDANCE ON MANAGING PERSONAL VALUES AND BELIEFS

73.1. HS introduced 16.10.C.03 which informed Council about the GPhC’s plans to develop and consult on guidance that supported managing personal values and beliefs when delivering person-centred care.

73.2. Council noted the approach to developing guidance about managing personal values and beliefs when delivering person-centred care.

74. PROFESSIONAL STANDARDS AUTHORITY ANNUAL PERFORMANCE REVIEW 2015–16


74.2. Council noted the Professional Standards Authority annual performance review 2015–16 and commended the team on their excellent work.

75. ANY OTHER BUSINESS

75.1. In response to a member’s question about encouraging more public engagement in Council meetings, Council was reminded that public engagement featured in the wider review of Council’s efficiency and effectiveness – as per the presentation and discussion at 8 September 2016 Council workshop.

75.2. There being no further public business, the meeting closed at 3pm.

DATE OF NEXT MEETING

Thursday, 10 November 2016
## Council actions log

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Ref.</th>
<th>Action</th>
<th>Owner</th>
<th>Due date</th>
<th>Status</th>
<th>Comments/update</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Oct 16</td>
<td>72.3(v)</td>
<td><strong>Standards for pharmacy professionals</strong>: Council delegated authority to the Chair of Council to sign off the standards, with the proviso that any substantial changes to wording be circulated to Council for agreement before sign off.</td>
<td>Hugh Simpson</td>
<td>Nov 16</td>
<td>Open</td>
<td>To be covered under agenda item 7.</td>
</tr>
</tbody>
</table>
Council meeting 10 November 2016

Public business

September 2016 Registration Assessment

Purpose
To update Council on candidate performance in the September 2016 Registration Assessment.

Recommendations
Council is asked to note:

(i) the Board of Assessor’s report to Council (Appendix 1)
(ii) candidate performance data and the discussion of issues of potential wider relevance in this report (Appendix 2)

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 September 2016 sitting.

1.2 The Registration Assessment is set and moderated by the Board of Assessors (the Board) on behalf of the GPhC. The Board presents a paper to the GPhC’s Council after each sitting. The Board’s report on the September 2016 sitting is at Appendix 1.

1.3 The September 2016 sitting was the second of a new style examination – details of which can be found at http://www.pharmacyregulation.org/2016changes .

\(^1\) Except for EEA pharmacists.
2. **The Board’s report and related matters**

2.1 The Board’s report is an overview of the September 2016 sitting, and this companion paper highlights issues derived from the report that are of potential wider relevance.

2.2 *Publication of data:* Consistent with our commitment to releasing data we hold about the Registration Assessment, performance data by characteristic are presented in Appendix 2. The September sitting was considerably smaller than June’s which means that data in some categories have been omitted to preserve candidate anonymity. Where this is the case, the break points for excluding data have been made clear.

2.3 *Pass rate and cohort profile:* The pass rate for the September sitting is low, especially in comparison to the June pass rate of 95%, but, as the Board of Assessors has pointed out, the June and September cohorts are quite different. It is striking that June comprised mainly first sitting candidates (93%) whereas over 40% of the September cohort were resitting. The data shows that second and third sitting candidates performed less well than the first sitters, which is a concern but consistent with the performance of resitting candidates in previous September cohorts.

2.4 *Trends:* as was the case in June, the performance of candidates by characteristics such as ethnicity, country of training and sector of practice are consistent with underlying trends:

   i. Scottish trainees continue to out-perform their English counterparts;

   ii. hospital trainees continue to out-perform their community counterparts; and

   iii. candidates from some ethnic groups continue to out-perform others, with the rank ordering remaining broadly the same.

2.5 *Feedback on the sitting:* As an organisation, the GPhC welcomes feedback on its work and has received feedback on the September sitting, which the BPSA has collated and presented to us as a report. As is clear from the Board’s report at Appendix 1, the BPSA’s recommendations were discussed fully and responses to all the points have been prepared and sent to the BPSA. The GPhC and the Board will continue its dialogue with the BPSA about the Registration Assessment, to be as open and transparent as possible about this important professional examination.

3. **Equality and diversity implications**

3.1 The data in Appendix 2 do present performance by protected characteristics in some instances and may have equality and diversity implications requiring further discussion and consideration.
3.2 Council will receive a report of our recent seminar relating to ethnicity and academic performance within pharmacy education and training at its December meeting.

4. Communications

4.1 The Board’s report and this paper will be shared directly with schools of pharmacy, the BPSA, pre-registration training providers and pre-registration funders.

5. Resource implications

5.1 There are no current resource implications for the GPhC.

6. Risk implications

6.1 There are no risk implications.

Recommendations

Council is asked to note:

(i) the Board of Assessor’s report to Council at Appendix 1
(ii) candidate performance data and the discussion of issues of potential wider relevance in this report at Appendix 2

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

25th October 2016
Report to the General Pharmaceutical Council’s governing council on the September 2016 registration assessment

1. Introduction

1.1 The initial education and training of pharmacists in Great Britain is:

- A four-year MPharm degree accredited by the GPhC; then
- 52 weeks of pharmacist pre-registration training; and
- the GPhC’s registration assessment.

1.2 During pre-registration training, trainees are signed-off on four occasions by a designated pharmacist 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 The registration assessment is an examination with two papers: part 1 (morning) and part 2 (afternoon).

1.4 Part 1: The part 1 paper is two hours long (120 minutes) and comprises 40 calculations questions.

1.5 Part 2: The part 2 paper is two and a half hours long (150 minutes) and comprises 120 questions: 90 are single best answer questions (SBAs) and 30 are extended matching questions (EMQs).

1.6 Resource packs are provided for candidates, one for each part, and candidates are not permitted to bring any reference sources to the sitting. Examples of resources provided include extracts from reference sources such as the BNF and summaries of product characteristics (SPCs).

1.7 Candidates with a specific need may ask for an adjustment to be made in the conduct of the assessment.

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1 Non-EEA pharmacists wanting to register in GB take a one-year university Overseas Pharmacists’ Assessment Programme (OSPAP) instead of an MPharm degree.
2. **Reporting to council**

2.1 There are two sittings of the registration assessment every year, in June and September, and the board of assessors reports to the GPhC’s council after each one. This is the report for September 2016 (including some data from the June sitting for comparative purposes).

3. **September 2016 summary statistics**

<table>
<thead>
<tr>
<th>Candidate numbers</th>
<th>September 2016</th>
<th>June 2016 (for comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of total</td>
</tr>
<tr>
<td>Total number of candidates</td>
<td>660</td>
<td>100%</td>
</tr>
<tr>
<td>Number of first sitting candidates</td>
<td>393</td>
<td>59.5%</td>
</tr>
<tr>
<td>Number of second sitting candidates</td>
<td>135</td>
<td>20.5%</td>
</tr>
<tr>
<td>Number of third sitting candidates</td>
<td>132</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Candidate performance – pass rates</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall pass</td>
<td>269</td>
<td>40.76%</td>
</tr>
<tr>
<td>Overall fail</td>
<td>391</td>
<td>59.24%</td>
</tr>
<tr>
<td>First sitting candidates - pass</td>
<td>187</td>
<td>47.58%</td>
</tr>
<tr>
<td>Second sitting candidates - pass</td>
<td>30</td>
<td>22.22%</td>
</tr>
<tr>
<td>Third sitting candidates - pass</td>
<td>52</td>
<td>39.39%</td>
</tr>
</tbody>
</table>

3.1 As is always the case, the September sitting was smaller than the June sitting. The most important characteristic of the sitting however is the balance between first, second and third sitting candidates: whereas first sitting candidates predominate in June sittings, September sittings comprise far larger percentages of second and third sitting candidates, that is candidates who were resitting, having been unsuccessful in previous sittings. The concentration of resitting candidates in September sittings does mean that the pass rate tends to be lower than in June.

3.2 The total pass rate for all candidates who sat the registration assessment in 2016 is 84.93%. In previous years, the overall pass rate for the year has ranged between 71.37% and 89.53%.

4. **Paper and question analysis**

Changes to the 2016 papers

4.1 For the last 2-3 years the board has been developing a revised registration assessment using an evidence-based standard setting process and ensuring the content reflects a more patient-centred focus. This has been to reflect changes in the profession and to
ensure that the assessment remains fit for purpose. The first sitting using the new style was June 2016 and September 2016 was the second.

**Question performance**

4.2 After the sitting the performance of all questions was analysed and across the two papers and on the basis of question performance, 5 were removed from Part 2. No questions were removed from Part 1.

**The balance of questions**

4.3 All papers are constructed in accordance with an agreed template: this process in known as blueprinting. The board issued comprehensive guidance on the construction of papers in its registration assessment framework, which can be accessed at [www.pharmacyregulation.org/53-registration-assessment-framework](http://www.pharmacyregulation.org/53-registration-assessment-framework). The framework includes guidance on the weighting of syllabus areas and also the inclusion of guidance on therapeutic areas and high risk drugs likely to be covered. The table below confirms that the papers accurately reflected the allocation of weightings in the framework:

| Total % of questions - high weighted outcomes | 66.3 |
| Total % of questions - medium weighted outcomes | 28.1 |
| Total % of questions - low weighted outcomes | 5.6 |

No question can be used in a paper without being assigned to a syllabus area.

**Pass rate**

4.4 It has been the case for some time that pass rates for the September sitting tend to be lower than those for June sittings. The profile of September sittings is always markedly different from June. This appears to be a consequences of June sittings being almost entirely comprised of first sitting candidates, whereas September comprises far more resitting candidates. An additional factor is that significant numbers of first sitting candidates sat in September either because they chose to withdraw in June or were ineligible to sit at that stage because they may have entered pre-registration training late after having failed MPharm degree assessments (or for other reasons).

4.5 One conclusion that can be drawn from 4.4 is that September cohorts are likely to be weaker because significant numbers have failed elements of their initial education and training already. The reliability index the board uses – Cronbach alpha – shows that the September sitting has reliability in the ‘good’ range, which means that better candidates were more likely to pass than weaker ones and that the sitting was a good reflection of candidate ability.

**Comparing questions**
4.6 Given the difference in pass rates between the two 2016 sittings, the board undertook a comparison of question performance between the two. While some questions performed similarly some did not and it was striking that the performance of some similar questions in Part 1 demonstrated significantly weaker performance in September. Two sets of questions are reproduced below as examples. The performance in September suggests that the cohort was weaker than the June cohort.

**Question 1**

**September 2016**

A prescriber asks you to prepare 100 g of a 1 in 5 dilution of hydrocortisone butyrate 0.1% ointment. The recommended diluent is emulsifying ointment.

How many grams of hydrocortisone butyrate ointment 0.1% are needed to prepare the requested ointment?

**Facility**: 31%

**June 2016**

A prescriber asks you to prepare 150 g of a 1 in 5 dilution of Locoid ointment. The recommended diluent is emulsifying ointment.

How many grams of Locoid ointment are required for the 1 in 5 dilution?

**Facility**: 85%

**Question 2**

**September 2016**

An 8-year-old boy weighs 28 kg and has hypokalaemia. He requires potassium chloride 2 mmol/kg to be given intravenously over 12 hours. An infusion bag containing potassium chloride 0.3% and glucose 5% is being used to treat his hypokalaemia.

Information on the electrolyte content of various infusion fluids can be found in the extract adapted from the BNF that is provided in your resource pack.

What is the infusion rate in mL/hour required to deliver the prescribed dose? Give your answer to the nearest whole number.

**Facility**: 55%

**June 2016**

Child N weighs 12.8 kg and has hypokalaemia. He requires potassium 2 mmol/kg to be given intravenously over 12 hours. An infusion bag containing potassium chloride 0.3% and sodium chloride 0.9% is being used to treat his hypokalaemia.

Information on the electrolyte content of various infusion fluids can be found in the extract adapted from the BNF that is provided in your resource pack.

What is the infusion rate in mL/hour required to deliver the prescribed dose? Give your answer to one decimal place.

**Facility**: 84%

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2 ‘Facility’ is the proportion of candidates who selected the correct answer. It is presented here as a percentage.
September sittings in general

4.7 The board wishes to raise a general point about September sittings which is that the pass rate is likely to continue to be lower than in June due to the different profile of candidates. Now that the board receives enhanced statistical data on performance, its more empirical observations about weak cohort performance are being backed up by objective data. June and September sittings are only three months apart and it is debatable how much a candidate can improve in that time. The board is not suggesting there should be a change in the pattern of sittings at this stage but it will continue to monitor cohort performance in future years to see whether further evidence suggests a change might be in the best interest of candidates.

5. Feedback to candidates

Feedback for candidates will be incorporated into the usual November review of the online pharmacist pre-registration training manual.

6. Feedback from the British Pharmaceutical Students Association (BPSA)

At its meeting on 19-20 October the board considered a report on the September sitting from the BPSA. The report was a constructive and helpful document, which the board welcomed. The BPSA made eight recommendations and the board has prepared a response to each one.

‘Recommendation 1: The GPhC should review the number and content of the questions in Paper 1 to ensure candidates are able to attempt the questions in the designated time limit.’

The board’s response:

Number of questions: Before introducing the new style Part 1 calculations paper, the format and number of questions was piloted and non-completion was not an issue (neither was it in June). Rather than there being a problem with the Part 1 paper in September, the data suggests that the cohort was weaker compared to June, which may explain why some candidates were unable to complete the paper.

Content of questions: The content of the questions is based on the registration assessment framework, which includes an indicative list of calculations question types for Part 1. Once questions have been written by practising pharmacists they are evaluated by standards setters, again who are practising pharmacists with experience of pre-registration trainees/early years pharmacists, and who verify that the questions are suitable and realistic to be answered by pre-registration trainee pharmacists.

‘Recommendation 2: The GPhC should continue to provide formulas for calculations and inform candidates of formulas to memorise and be familiar, working with the BPSA to resolve.’
The board’s response: The board’s policy on using formulae is that if a relatively complex formula is needed to answer a question it is provided – in the Part 1 paper the Cockcroft-Gault formula was provided, for example. The only other formulas required to answer questions are very simple and should be known and used regularly by trainees in practice – calculating a BMI would be a case in point. After considering the recommendation, the board agreed that it would not be appropriate to provide a list of such simple formulae.

‘Recommendation 3: The GPhC should ensure the assessment composes of a proportionate balance of questions from different areas of the framework.’

The board’s response: The board follows a blueprint, which sets parameters for the numbers of questions included across syllabus areas: this blueprint is the same for all papers and is always followed. In the registration assessment framework, weightings are assigned to each syllabus area so candidates can judge the proportion of questions there will be on particular topics. Ensuring that topics are covered does not necessarily mean that a question will be set on a specific subject, which is a common misconception by candidates.

Recommendation 4: The GPhC should prepare a more detailed and accurate framework to prepare pre-registration trainees, and work with the BPSA gaining a better understanding into what makes a detailed framework.’

The board’s response: The board has discussed this matter on many occasions and is clear that the framework is set at the right level. The board has resisted requests for a more detailed document deliberately because in its experience such documents tend to be treated as definitive topics/medicines lists by candidates. Pharmacy is so broad that the number of items on such lists would always exceed the number of available questions and it is inevitable that papers can only test a proportion of the total. In the board’s experience, seeing an item on a list can create an (incorrect) assumption that knowledge of it will be tested.

Candidates should be reassured that the framework is reviewed annually by the board to ensure that it is up-to-date.

‘Recommendation 5: The GPhC should review the time allocated for Paper 2 and review the question format used.’

The board’s response:

Time allocation: While not all candidates answered every question in September, there is no verifiable evidence to suggest that the time allocation for Part 2 paper is inappropriate.

Question format: The decision to use single best answer questions and extended matching questions from 2016 was taken by the board after a review of research literature; the evidence indicates they are the most effective way of testing clinical knowledge in written MCQ examinations. The board agreed that having undertaken an evidence-based review of question types so recently there is no reason to do so again.
‘Recommendation 6: The GPhC should ensure that the assessment resembles day-to-day practice.’

The board’s response: The board strongly agrees with this recommendation and it was one of the principal justifications for revising the format of papers. It is also the justification for using practising front-line pharmacists as standards setters, with a core part of their role being to ensure that all questions are relevant and appropriate.

‘Recommendation 7: The GPhC should review the number of SPC questions and ensure the quality of these resources are suitable for candidates in terms of content and ability to use in the assessment.

The board’s response: The board takes care to ensure that the SPCs used in the assessment are common ones. Candidates should know the format of SPCs, because it is standardised, and should, therefore, know where to find information within them.

The ‘quality’ of SPCs is not something the board can control because they are written by manufacturers.

Spread of artefact questions: Questions requiring the use of artefacts in Part 2 were spread across the paper, from question 3 to question 120. There were 18 such questions in the 90-question single best answer section and eight such questions in the 30-question extended match question section.

‘Recommendation 8: The GPhC should provide trainees with more specimen questions, reflecting the actual assessment.’

Board’s response: The board will continue to issue example questions. Considering the point about the relevance of example questions to actual questions in papers, the board thinks it is important to make clear that all are written by the same question writers and that all are considered at the same time by the board. This is how the board assures itself that there is equity across example questions and questions used in papers.

On a related point, the board agreed it was important to make clear that there are no differences between questions for June and September papers in that they are commissioned from the same question writers and the writers do not know whether the questions they write will be used in a particular paper.

The board has agreed to contact the BPSA Executive about arranging a follow-up meeting to discuss the registration assessment at greater length.

Professor Andrew Husband on behalf of the board of assessors
26 October 2016
## September 2016 Registration Assessment performance breakdown by characteristic

### Table 1: Overall performance

<table>
<thead>
<tr>
<th>No. of candidates</th>
<th>Overall Pass Rate</th>
<th>Total raw marks available</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average % mark</td>
<td>Average % mark</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Raw mark (/40)</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Raw mark (/115)</td>
<td>%</td>
</tr>
<tr>
<td>660</td>
<td>40.76%</td>
<td>40</td>
<td>25.41</td>
<td>63.25</td>
</tr>
</tbody>
</table>

*There are 120 questions in Part 2 but five questions was removed after the sitting (see the Board’s report to Council for further details).

### Table 2: Performance by sitting attempt

<table>
<thead>
<tr>
<th>Sitting attempt</th>
<th>No. of candidates</th>
<th>Overall Pass Rate</th>
<th>Total raw marks available</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Average % mark</td>
<td>Average % mark</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Raw mark (/40)</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Raw mark (/115)</td>
<td>%</td>
</tr>
<tr>
<td>1st</td>
<td>393</td>
<td>47.58%</td>
<td>40</td>
<td>26.35</td>
<td>65.87</td>
</tr>
<tr>
<td>2nd</td>
<td>135</td>
<td>22.22%</td>
<td>40</td>
<td>23.45</td>
<td>58.63</td>
</tr>
<tr>
<td>3rd</td>
<td>132</td>
<td>39.39%</td>
<td>40</td>
<td>24.61</td>
<td>61.53</td>
</tr>
</tbody>
</table>

Note that data in Table 3 onwards are for 1st attempt sitters not the full cohort.

### Table 3: 1st attempt by education route

<table>
<thead>
<tr>
<th>Education Route</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Part 1</td>
</tr>
<tr>
<td>OSPAP</td>
<td>27</td>
<td>37.04%</td>
<td>64.72</td>
</tr>
<tr>
<td>MPharm</td>
<td>366</td>
<td>48.36%</td>
<td>65.96</td>
</tr>
</tbody>
</table>
### Table 4: 1st attempt by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average</th>
<th>% mark</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>167</td>
<td>53.29%</td>
<td>67.89</td>
<td>71.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>226</td>
<td>43.36%</td>
<td>64.38</td>
<td>70.48</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5: 1st attempt by age range

<table>
<thead>
<tr>
<th>Age Range</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average</th>
<th>% mark</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 and over</td>
<td>38</td>
<td>26.32%</td>
<td>55.72</td>
<td>65.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26-35</td>
<td>99</td>
<td>29.29%</td>
<td>59.67</td>
<td>68.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 or under</td>
<td>256</td>
<td>57.81%</td>
<td>69.78</td>
<td>72.58</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 6: 1st attempt by country of training

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average</th>
<th>% mark</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wales</td>
<td>Candidate numbers too low to report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td>26</td>
<td>76.29%</td>
<td>73.37</td>
<td>74.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>365</td>
<td>45.48%</td>
<td>65.40</td>
<td>70.54</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 7: 1st attempt by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average</th>
<th>% mark</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>44</td>
<td>65.91%</td>
<td>71.70</td>
<td>75.47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>349</td>
<td>45.29%</td>
<td>65.14</td>
<td>70.16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were no candidates from academia/industry
### Table 8: 1st attempt by ethnicity (≥ 40 candidates in a category)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>44</td>
<td>70.45%</td>
<td></td>
<td>75</td>
<td>77.43</td>
</tr>
<tr>
<td>Black - African</td>
<td>48</td>
<td>33.33%</td>
<td></td>
<td>56.51</td>
<td>67.66</td>
</tr>
<tr>
<td>Indian</td>
<td>68</td>
<td>44.12%</td>
<td></td>
<td>65.88</td>
<td>70.81</td>
</tr>
<tr>
<td>Pakistani</td>
<td>84</td>
<td>50%</td>
<td></td>
<td>63.93</td>
<td>69.80</td>
</tr>
</tbody>
</table>

### Table 9: MPharm degree 1st attempt by School of Pharmacy (≥ 15 candidates)

<table>
<thead>
<tr>
<th>School of Pharmacy</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aston University</td>
<td>19</td>
<td>57.89%</td>
<td></td>
<td>71.71</td>
<td>73.64</td>
</tr>
<tr>
<td>University of Bradford (5-year sandwich)</td>
<td>28</td>
<td>42.86%</td>
<td></td>
<td>63.48</td>
<td>67.76</td>
</tr>
<tr>
<td>De Montfort University</td>
<td>32</td>
<td>59.38%</td>
<td></td>
<td>65.63</td>
<td>74.92</td>
</tr>
<tr>
<td>Keele University</td>
<td>20</td>
<td>25%</td>
<td></td>
<td>57.38</td>
<td>63.65</td>
</tr>
<tr>
<td>Kingston University</td>
<td>42</td>
<td>33.33%</td>
<td></td>
<td>59.59</td>
<td>68.14</td>
</tr>
<tr>
<td>Liverpool John Moores University</td>
<td>15</td>
<td>55.33%</td>
<td></td>
<td>65.50</td>
<td>69.80</td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>17</td>
<td>47.06%</td>
<td></td>
<td>77.21</td>
<td>71.46</td>
</tr>
<tr>
<td>Robert Gordon University</td>
<td>16</td>
<td>68.75%</td>
<td></td>
<td>71.09</td>
<td>73.42</td>
</tr>
<tr>
<td>University of Strathclyde</td>
<td>21</td>
<td>71.43%</td>
<td></td>
<td>73.93</td>
<td>74.53</td>
</tr>
<tr>
<td>University of Sunderland</td>
<td>15</td>
<td>60%</td>
<td></td>
<td>69.17</td>
<td>73.86</td>
</tr>
<tr>
<td>University College London</td>
<td>23</td>
<td>34.78%</td>
<td></td>
<td>65.11</td>
<td>71.23</td>
</tr>
</tbody>
</table>

Note that data are not presented by OSPAP provider because candidate numbers are too low for anonymity to be preserved.

Data are not presented for schools of pharmacy presenting < 15 candidates for the same reason.
Public business

Consultation on standards for the IET of pharmacy technicians

Purpose
To discuss and agree a consultation on revised initial education and training standards for pharmacy technicians.

Recommendations
The Council is asked to agree the proposed consultation as set out in (Appendix 2) on revised standards for the initial education and training of pharmacy technicians.

1. Introduction
1.1 Pharmacy technicians play a vital role in delivering care and helping people to maintain and improve their health, safety and wellbeing. The professionalism they demonstrate is central to maintaining trust and confidence in pharmacy. That professionalism is grounded in initial education and training that is fit for purpose.

1.2 Pharmacy technicians are a relatively newly regulated profession with full statutory and compulsory registration coming into force in 2011.

1.3 The current standards for the initial education and training (IET) of pharmacy technicians were adopted by the GPhC in 2010 when it took over responsibility for pharmacy regulation from the previous regulator.

1.4 It is important that the initial education and training standards for pharmacy technicians reflect both current practice and are flexible enough to take into account the ongoing developments in pharmacy and the wider healthcare sector.

1.5 This consultation exercise should ensure that early career pharmacy technicians continue to be equipped not only with the knowledge, skills and competence to perform their role, but also the professionalism and decision making capability necessary to be a healthcare professional.
2. **Developing new standards**

2.1 The standards development process began several years ago when two significant pieces of research were commissioned: one from the University of Manchester into the current state of pharmacy technician IET (2014) and one from University College London/London Pharmacy Education and Training into pharmacy technician IET strengths and weaknesses (2015).

2.2 Prior to that, in 2013, we had commissioned a major survey about our registrants from NatCen which, for the first time, gave us a solid, evidenced-based picture of the pharmacy technician population.

2.3 More recently we issued two significant discussion documents relevant to pharmacy technician IET, *Educating the Pharmacy Team* (2015) and *Standards for Pharmacy Professionals* (2016). Most recently (October 2016) the University of East Anglia and the Association of Pharmacy Technicians UK (APTUK) issued a study *Identifying the roles of Pharmacy Technicians in the UK*.

2.4 This work has given us an improved evidence base about the range of roles undertaken by pharmacy technicians, as well as the requirements of their initial education and training. The proposals in the consultation document were informed by the extensive engagement undertaken in the last two years and the evidence base with have gathered.

2.5 We were also supported in developing these draft standards by an external group with expertise and knowledge of pharmacy technician education and training. There were members from all three countries we regulate (as well as attendance from Northern Ireland), a variety of sectors of practice, course commissioners and course providers. A full list of those representatives who helped us is set out in Appendix 1.

2.6 It should be noted that while we received external feedback from this group with significant expertise, they were not asked to agree or provide feedback on a final version of the draft learning outcomes as this is a matter which is reserved to Council in law.

2.7 Council has had an opportunity to provide informal feedback on a previous draft of the consultation document and draft standards which we hope is reflected in the current version set out in appendix 2.

3. **Key considerations**

3.1 *Structure of the consultation document*

3.2 The format of the revised standards is quite different from the current ones and is a significant step forward in describing IET for the pharmacy technician profession.

3.3 It is in three parts which cover linked but distinct aspects of the regulation of initial education and training.
3.4 Part 1 describes the IET for pharmacy technicians as learning outcomes (covering the whole role for the first time) and Part 2 describes the requirements for national qualifications and courses which will deliver the learning outcomes in Part 1.

3.5 If the standards are right then the learning outcomes in Part 1 will describe accurately the required knowledge, skills, understanding and professional behaviours needed by an early career pharmacy technician and Part 2 will be an appropriate framework for developing qualifications and courses delivering the learning outcomes in Part 1.

3.6 Part 3 identifies specific aspects of the registration criteria which we are considering and wish to consult on.

3.7 We see the change in structure as important both to provide clarity about expectations of the trainee, but also clarity about the expectations and requirements on awarding bodies and course providers. These changes also reflect a more modern approach to drafting and designing initial education and training standards for health professionals.

3.8 Learning outcomes

3.9 Council will note the updated format of the learning outcomes we are setting out for consultation. In particular we have not only set out draft learning outcomes, but also the competence and assessment hierarchy based on ‘Miller’s triangle’. This is the format we currently use for pharmacist initial education and training standards.

3.10 Council will also wish to note that the learning outcomes have been updated to reflect feedback we heard in our pre-consultation engagement. In particular, that some elements of a pharmacy technician role which historically were seen as advanced practice are now core to that role.

3.11 Where this is the case, these should be reflected in the new draft standards. Examples of this include:

   i. the ability to carry out accuracy checking;

   ii. the requirement for newly qualified pharmacy technicians (like pharmacists) to be able to understand core safety concepts such as clinical and corporate governance, as well as audit; and

   iii. their ability to work both within and across teams.

3.12 Reviewing registration requirements

3.13 In addition to developing revised IET standards for pharmacy technicians we have revisited the criteria we set for pharmacy technicians to be entered in the register. The criteria set out the route to and requirements for registration. Many of the requirements set out in the criteria are historical and were put in
place when pharmacy technicians first became a registered profession in 2005 and need updating.

3.14 The criteria are in two parts. The first sets out the qualifications and work experience requirements for initial registration as a pharmacy technician with the GPhC. The second sets out the requirements for those wishing to return to registration as a pharmacy technician.

3.15 We are considering some changes to part one as a result of feedback we have received from stakeholders and to reflect Council’s commitment to outcomes focussed and proportionate regulation. We would welcome feedback on the three areas we wish to explore during the consultation which are:

i. The supervision requirements for pre-registration trainee pharmacy technicians

ii. The two-year work experience requirement

iii. The option that exists for current or recently retired registered pharmacists to register as a pharmacy technician

4. Next steps

4.1 If the consultation draft is approved by Council, it will be issued for public consultation on 23 November 2016 and the consultation will close on 1 March 2017.

4.2 Council would be provided, as is normal practice, with a report of the consultation and be asked to consider updated draft set of standards for approval.

4.3 We would expect those updated standards to be published in September 2017. As is normal practice for education standards, they would be rolled out over a period of time.

5. Equality and diversity implications

5.1 Through the work outlined in Section 2, the GPhC now has a good understanding of the pharmacy technician population. In the development of the draft standards and consultation document, we have not identified any specific equalities and diversity implications.

5.2 However, we do know from our analysis of data on the outcomes of education and training for pharmacists that there are issues about performance amongst certain groups of students and we will seek feedback on equality and diversity implications as part of our consultation.
5.3 We have also drawn attention to the potential for changes to time based registration requirements to impact equality and diversity. We would welcome feedback from Council on this, or any other issues identified.

6. Communications
6.1 The consultation document will be issued publicly on 23 November 2016 and will be promoted through our website and social media.
6.2 A series of events will be run both as part of the consultation process and then to publicise the outcome of the consultation and subsequent revisions to the standards.
6.3 The final version of the standards will be sent to all relevant stakeholders once they have been agreed in 2017 at the end of the development process.

7. Resource implications
7.1 The consultation process will be managed within existing resources in the Strategy Directorate.

8. Risk implications
8.1 The principal and substantial risk of not consulting on and agreeing revised IET standards is that IET will diverge from practice and new registrants will be ill equipped to face the challenges of their profession when registered.
8.2 However, it is critical that we engage a wide range of stakeholders in this process so that we can identify and further implications not previously considered as well as understand any particular gaps in oversight or regulation of pharmacy technician education and training.
8.3 We are also aware that the UK Rebalancing initiative\(^1\), looking at the balance between medicines law and professional regulation, could lead to proposals about the role of pharmacy technicians in supervision of medicines. However, we believe the draft education standards, being focussed on learning outcomes, would remain relevant should ministers decide to make any proposed changes.

9. Monitoring and review
9.1 Standards will have to be translated into qualifications and courses and the first test will be whether they can deliver the learning outcomes in the standards. This will be reviewed and evaluated by experts through the GPhC’s education quality assurance processes.
9.2 Course providers will submit data to the GPhC on an annual basis as part of a more substantial monitoring and review process for pharmacy technician education.

\(^1\) https://www.gov.uk/government/groups/pharmacy-regulation-programme-board
IET, which the GPhC will develop when it revises its accreditation processes in 2017.

9.3 For the last three years, the GPhC has surveyed pre-registration trainee pharmacists/pre-registration tutors (both twice) and pre-registration trainee pharmacy technicians (once). The survey cycle has now ended and the GPhC has an opportunity to consider how best to survey trainees in the future, which could include surveys on the preparedness for practice of recently registered pharmacy technicians, based on their IET.

Recommendations

The Council is asked to agree the proposed consultation as set out in (Appendix 2) on revised standards for the initial education and training of pharmacy technicians.

_Damian Day, Head of Education_
_General Pharmaceutical Council_
_damian.day@pharmacyregulation.org_

03 November 2016
## Appendix 1
### External expert group membership

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalgeet Puaar</td>
<td>Association of Pharmacy Technicians UK (APTUK) Education Team Lead</td>
</tr>
<tr>
<td>Tess Fenn</td>
<td>APTUK and City and Guilds</td>
</tr>
<tr>
<td>Chris Wilmot</td>
<td>APTUK nominee (pre-registration trainee pharmacy technician)</td>
</tr>
<tr>
<td>Johnesia Francis</td>
<td>APTUK nominee (pre-registration trainee pharmacy technician)</td>
</tr>
<tr>
<td>Raminder Sihota</td>
<td>Boots</td>
</tr>
<tr>
<td>Gail Holmes</td>
<td>Bradford College</td>
</tr>
<tr>
<td>Helen Abbott</td>
<td>Buttercups Training</td>
</tr>
<tr>
<td>Barbara Wensworth</td>
<td>Hospital pharmacist and former pharmacy technician course lead at Bradford</td>
</tr>
<tr>
<td>Aniket Parikh</td>
<td>CIG Healthcare Partnership</td>
</tr>
<tr>
<td>Dr Elspeth Weir</td>
<td>Community Pharmacy Scotland</td>
</tr>
<tr>
<td>Deborah Williams</td>
<td>Centre for Pharmacy Postgraduate Education (CPPE)</td>
</tr>
<tr>
<td>Jeanne Wood</td>
<td>Dispensing Doctors’ Association</td>
</tr>
<tr>
<td>Elizabeth Fidler</td>
<td>Health Education Kent Surrey and Sussex</td>
</tr>
<tr>
<td>Preeti Vijj</td>
<td>Lloyds</td>
</tr>
<tr>
<td>Melanie Boughen</td>
<td>NHS East of England</td>
</tr>
<tr>
<td>Val Findlay</td>
<td>NHS Education Scotland</td>
</tr>
<tr>
<td>Helen Fawcett</td>
<td>NHS North East Pharmacy Education &amp; Training</td>
</tr>
<tr>
<td>Helga Mangion</td>
<td>NPA/Pharmacy Voice</td>
</tr>
<tr>
<td>Cheryl Bott</td>
<td>Pearson’s</td>
</tr>
<tr>
<td>Jonathan Gillies</td>
<td>Scottish Qualifications Authority</td>
</tr>
<tr>
<td>Sarah Wilcox</td>
<td>Cardiff and Vale University Health Board</td>
</tr>
<tr>
<td>Donna Bartlett</td>
<td>Pharmacy Technician registrant</td>
</tr>
<tr>
<td>Graham Jagger</td>
<td>Patient group representative</td>
</tr>
<tr>
<td>Michelle Sehrawat</td>
<td>Workforce, Education and Development Services, Wales</td>
</tr>
<tr>
<td>Tracey Burrows</td>
<td>NHS London Pharmacy Education and Training</td>
</tr>
<tr>
<td>Mark Anderson</td>
<td>Ministry of Defence</td>
</tr>
<tr>
<td>Brendan Kerr (Observer)</td>
<td>Pharmaceutical Society of Northern Ireland (PSNI)</td>
</tr>
</tbody>
</table>
Consultation on initial education and training standards for pharmacy technicians

November 2016
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About the GPhC
Developing the standards
The consultation process
Background
Part 1 Initial education and training standards for pharmacy technicians – learning outcomes
Part 2: Standards for IET course providers
Part 3: Changes to the criteria for registration as a pharmacy technician
Consultation response form

The deadline for responding to this consultation is Wednesday 1 March 2017.
Foreword

There are growing expectations on everyone working within health and care – including pharmacy – to give better-quality experiences and outcomes to patients and the public.

Our Strategic Plan (2017-20) sets out our aim to use our regulatory powers to support and improve the delivery of safe, effective care and uphold trust in pharmacy. One of the ways we intend to do this is by continuing to ensure the pharmacy team have the necessary knowledge, attitudes and behaviours.

It is vital that the pharmacy team are equipped to work flexibly alongside other health and care professionals so they can respond with confidence to the changing needs of people and populations needing care. This is central to ensuring that best use is made of the knowledge, attitudes and behaviours of every member of the pharmacy team so they can deliver pharmacy services and improve them. A vital part is played by the standards of initial education and training we set for the initial education and training of pharmacy technicians who are providing a vital and increasing role in the delivery of pharmaceutical care.

It is clear from our engagement with the sector, and the feedback we have received from our discussion paper, *Tomorrow’s pharmacy team (2015)*, that, although they are a relatively recently regulated professional group, pharmacy technicians are increasingly seen as crucial members of the healthcare workforce, with growing responsibilities and roles. Our research confirms that, in common with other professional groups, the profession is diverse and works in many different settings, delivering pharmaceutical care in increasingly complex ways.

Our aim for education and training – reflected in these standards – is that it must not only support pharmacy technicians’ learning of knowledge and skills, but also help inculcate them with clarity about professionalism, decision making and the ability to work within teams and autonomously.

The standards we are consulting on must reflect the roles that are required of pharmacy technicians now at the point of registration, as well as preparing pharmacy technicians of the future to take on increasing roles and responsibilities, if employers (both in the NHS and independent sectors) require it and if governments across Great Britain propose changes to legislation.

This document sets out draft standards for the initial education and training (IET) of pharmacy technicians that are designed to reflect this context.

We have drafted the new standards in two parts. Part 1 is a set of educational course learning outcomes informed by what we heard during our consultation with pharmacy professionals and patients about educating the pharmacy team (2015), and standards for pharmacy professionals (2016). If we have accurately reflected what we heard, the learning
outcomes should describe the knowledge, skills, understanding and professional behaviours needed by an early career pharmacy technician. Part 2 is a set of standards and requirements for course providers – the people whose courses will deliver the learning outcomes.

Pharmacy technicians have a valuable and important role in improving the health, safety and wellbeing of patients and the public and their initial education and training is central to that. We hope to hear from as many people and organisations as possible as we continue to develop our standards over the coming months.
About the GPhC

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacies in England, Scotland and Wales. It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.

Our main work includes:

- setting standards for the education and training of pharmacists, pharmacy technicians and approving and accrediting their qualifications and training
- maintaining a register of pharmacists, pharmacy technicians and pharmacies
- setting the standards that pharmacy professionals have to meet throughout their careers
- investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public
- setting standards for registered pharmacies which require them to provide a safe and effective service to patients
- inspecting registered pharmacies to check if they are meeting our standards.
Developing the standards

The GPhC has considered a range of information in developing the standards. We have heard from pre-registration trainee pharmacy technicians and pharmacy technicians. We have also considered the feedback we received from our discussion papers ‘Tomorrow’s pharmacy team’ (2015) and ‘Standards for Pharmacy Professionals’ (2016)\(^1\).

We were also supported in developing these draft standards by an external group with expertise and knowledge of pharmacy technician education and training.

We now want to test our thinking to make sure our new standards reflect the essential features of this profession. Please let us know what you think about any or all of the proposals described in this document.

The consultation will run for 14 weeks and will close on Wednesday 1 March 2017. During this time we welcome feedback from individuals and organisations. We will send this document to a range of stakeholder organisations, including professional representative bodies, employers, education and training providers, and patients’ representative bodies.

We hope you will read this paper and consider responding. You can get more copies of this document on our website www.pharmacyregulation.org/xxxxx or you can contact us if you would like a copy of the document in another format (for example, in a larger font or in a different language).

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The consultation process

\(^1\) This builds on our 2014 paper ‘Patient-centred professionalism in pharmacy’.
How to respond

You can respond to this consultation in a number of different ways. You can fill in the questionnaire at the end of this document or go to our website (link) and fill in an online version there.

If you fill in the questionnaire in this document, please send it to:

• Email consultations@pharmacyregulation.org with the subject ‘IET Standards for pharmacy technicians consultation’ or

• Post IET standards for pharmacy technicians consultation response
  Education Team
  General Pharmaceutical Council
  25 Canada Square
  London
  E14 5LQ

Comments on the consultation process itself

If you have concerns or comments about the consultation process itself, please send them to:

• Email feedback@pharmacyregulation.org or

• Post Governance Team
  General Pharmaceutical Council
  25 Canada Square
  London
  E14 5LQ

Please do not send consultation responses to this address.
Our report on this consultation

Once the consultation period ends, we will analyse the responses we receive. Analysis of the consultation will be presented to our governing Council at a meeting in summer 2017 and the responses received will be taken into account when considering the final IET standards for pharmacy technicians.

We will also publish a summary of the responses we receive and an explanation of the decisions taken. You will be able to see this on our website www.pharmacyregulation.org.
Background

Context

Pharmacy technicians play a vital role in delivering care and helping people to maintain and improve their health, safety and wellbeing. The professionalism they demonstrate is central to maintaining trust and confidence in pharmacy and that professionalism must be grounded in initial education and training that is fit for purpose.

Pharmacy technicians have been operating for some time, but only as part of a statutory compulsory register since 2011. It is important that all standards are reviewed and updated on a regular basis and this is our opportunity to ensure that the pharmacy technician IET standards set by us initially for the medium term reflect both the current and changing roles of the pharmacy technicians. Put another way, the core challenge of setting IET standards is to ensure that early career registrants – pharmacy technicians in this case – are provided not only with knowledge, skills and competence to perform the role of an ‘early years’ registrant, but also to equip them with decision making skills and a clear understanding of what it means to be a healthcare professional. It is this combination of knowledge, skills, behaviour and professionalism which will enable future registrants to develop to meet future demands.

Other relevant sources of information

In response to ‘Tomorrow’s pharmacy team’ we heard that you agreed with our proposition that professionalism, good communications and the ability to work in teams were core to all roles in the team. Our aim has been to embed all three embedded within the standards. In ‘Patient-centred professionalism’ we proposed that our new ‘Standards for Pharmacy Professionals’\(^2\) should be based on nine areas of practice:

\(^2\) Which will replace *Standards of conduct, ethics and performance*
Respondents agreed with us. As education and training standards are linked closely to practice standards it makes sense to map them on to each other in this context, which is what we have done.

As well as building in thinking from the consultation responses, we took into account two pieces of research commissioned by us in 2014 and 2015, one into the current state of initial pharmacy technician education and training in Great Britain and one into the views of pharmacy technician IET. We know from this work that new standards need a greater emphasis on professionalism and personal responsibility and that some obsolete technical procedures need to be removed.

Another very recent and valuable source of information about current and future roles for pharmacy technicians is a study commissioned by the Association of Pharmacy Technicians UK (APTUK). That study tells us that there are common cores to the roles in community and hospital pharmacy but also differences. It tells us too that whatever the sector of practice, pharmacy technicians must be responsible professionals with a range of skills and competencies. We hope you will see that our revised standards reflect this.

Pharmacy stakeholders also played an important role in helping us to develop our standards. Stakeholders from all three countries in Great Britain and a variety of settings with direct knowledge and experience of pharmacy technician education and training

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3 *The quality of pharmacy technician education and training* (Centre for Pharmacy Workforce Studies, University of Manchester, 2014) and *An analysis of the initial education and training standards for pharmacy technicians and views on their fitness for purpose* (University College London (UCL)/London Pharmacy Education and Training (LPET), 2015)

4 *Identifying the roles of Pharmacy Technicians in the UK* (APTUK/University of East Anglia, 2016)
worked with us to inform the development of these draft standards and provided a valuable sounding board during the development process.

The standards

These standards will apply to everyone training to be a pharmacy technician in Great Britain. Practising pharmacy technicians will work in a variety of contexts and their roles will change over time but our register does not make a distinction between sectors of practice. The purpose of IET is to equip early career pharmacy technicians with a broad base of skills and attributes that will enable them to work in a range of pharmacy settings across all the countries in Great Britain.

In the standards we have attempted to accurately reflect the expectations of early career pharmacy technicians: what the NHS and other employers need them to be able to do; the settings in which they will practice; as well as wider workforce requirements. These issues are key to setting the standards, providing a platform for registration as well as further education and training in more specialist roles.

A significant number of learning outcomes will be similar for both pharmacists and pharmacy technicians, but there are also important differences in both scope and level of training. The key challenge is to ensure both pharmacist and pharmacy technician IET standards reflect the reality of practice, knowledge and skills required.

Our current IET standards for pharmacy technicians make it clear that initial education and training must be undertaken in the workplace. However, in the research we commissioned and through direct feedback from stakeholders, a very clear message was that for learning to be as effective as possible there should be stronger links between course providers and employers, which we have built this into our standards.

The context in which pharmacy technician education and training is delivered is relevant to our standards as well. Courses are delivered alongside work; some are delivered face-to-face, some are delivered at a distance and some by a combination of the two. Writing standards for course providers that accommodate this diversity of provision is challenging and has been one of our key considerations.

Understanding the Pharmacy Technician role

Like pharmacists, and other healthcare professionals, the pharmacy technician role is a flexible one and varies between settings and sectors. Whatever the circumstances, pharmacy technicians play a part in the management of medicines as pharmacy/multi-professional team members, managers, and educators. The role’s inherent flexibility means that pharmacy technicians can work in registered pharmacies, primary, secondary and tertiary care and non-healthcare settings, or combinations of them.
We have also heard, through our pre-consultation engagement, that some elements of a pharmacy technician role which historically were seen as advanced practice are now core to that role. Where this is the case, these should be reflected in the new draft standards. Examples of this include: the ability to carry out accuracy checking; the requirement for newly qualified pharmacy technicians (like pharmacists) to be able to understand core safety concepts such as clinical and corporate governance, as well as audit; and their ability to work both within and across teams.

The structure of these standards

The standards set out the learning outcomes for pre-registration trainee pharmacy technicians. Our focus in the learning outcomes is for pre-registration trainee pharmacy technicians to provide high quality care, of which safety is a critical element. This is core to the education and training of all pharmacy professionals and this underpinning principle is embedded throughout these standards.

The standards are in two parts:

Part 1: IET standards for pharmacy technicians – learning outcomes: this part includes the required knowledge, skills, understanding and professional behaviours a pre-registration trainee pharmacy technician must demonstrate at the end of a course leading to registration with the GPhC; and

Part 2: Standards for IET course providers: this part includes the requirements of a course delivering the learning outcomes in Part 1.

While they are for different audiences, they are closely linked to each other, which is why they have been presented in one document.

Once the standards have been agreed we will issue companion guidance for course providers.
Part 1: IET standards for pharmacy technicians – learning outcomes

These standards are presented as learning outcomes, which include the professional behaviours, required skills, knowledge and understanding a pre-registration trainee pharmacy technician must demonstrate at the end of a course\(^5\). As a set, these learning outcomes describe a pre-registration trainee pharmacy technician who is fit to practise once registered.

We have grouped them under four domains, building on the three key themes in our consultation on the future pharmacy team (professionalism, communication and team working) and the standards for pharmacy professionals. The domains are:

1. Person-centred care
2. Professionalism
3. Professional knowledge and skills
4. Collaboration

The learning outcomes in ‘professionalism’ and ‘collaboration’ are more general and describe the attributes of a pharmacy professional. The learning outcomes in ‘professional knowledge and skills’ focus on the mechanics of the role and those in ‘person-centred care’ contextualize the knowledge and skills around the delivery of care.

Linking initial education and training and practice

Each of the four headings has been linked to a standard from our ‘Standards for Pharmacy Professionals’, of which there are nine, to show the link between IET and practice. Where appropriate we have included standards from ‘Standards for Pharmacy Professionals’ as learning outcomes:

<table>
<thead>
<tr>
<th>Person-centred care</th>
<th>Professionalism</th>
<th>Professional knowledge and skills</th>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred care</td>
<td>Effective communication</td>
<td>Respect for personal privacy and confidentiality</td>
<td>Professional behaviour</td>
</tr>
</tbody>
</table>

The standards include the term ‘person-centred care’ and refer to a ‘person’ throughout. This means ‘the person receiving care’. However, although we have not specifically mentioned carers or patients’ representatives, these terms apply to them too depending on the context. This is consistent with our use of ‘person’ in our ‘Standards for Pharmacy Professionals’.

\(^5\) Courses of initial education and training leading to eligibility to register are approved by the GPhC.
Part 2: Standards for IET course providers

Part 2 of the standards focus on the key features of courses that deliver the learning outcomes in Part 1. Pharmacy technician IET is delivered in a variety of different ways so it is important to note that the standards have been written in such a way that they are not prescriptive about delivery and should work equally well for face-to-face, distance and combined modes of delivery.

Accepting that delivery and design can be varied, in our view there are three documents essential for all courses:

- A teaching and learning strategy, to describe how the learning outcomes in Part 1 will be delivered
- An assessment strategy, to describe how the learning outcomes in Part 1 will be assessed, and
- A management plan, to describe who is responsible for what in the delivery of a course and the links between learning and work

In the standards we have been clear about what these documents must contain but in such a way that courses can be delivered, assessed and managed in quite different ways.

We have taken the same structural approach to the Part 2 of the standards by grouping them into domains:

1. Selection and entry requirements
2. Equality and diversity
3. Management, resources and capacity
4. Monitoring, review and evaluation
5. Course design and delivery
6. Course assessment
7. Pre-registration trainee pharmacy technician support and the learning experience

In each domain there are one or more standards followed by a number of requirements that have to be in place for a standard to be met.
Standards for the initial education and training of pharmacy technicians

Protecting patients and the public

Pharmacy professionals play a vital role in ensuring public and patient safety through providing safe and effective care. The safety of people is at the core of these standards and must be central in the education and training of pharmacy technicians across all learning environments. Public and patient safety is not a separate requirement and is embedded in all these standards and criteria. Programme providers and employers must prioritise public and patient safety in all aspects of the course and its delivery.

Part 1: learning outcomes

Standard: On successful completion of their initial education and training, pre-registration trainee pharmacy technicians will have achieved the learning outcomes in these standards.

Describing and assessing outcomes

We have derived the outcome levels in this standard from an established competence and assessment hierarchy, known as Miller’s triangle:

![Miller's Triangle Diagram]

As what is being assessed at each of the four levels is different, the assessment methods needed are different too, although there will be some overlap.
Level 1 – Knows: Knowledge that may be applied in the future to demonstrate competence. Assessments may include essays, oral examinations and multiple choice question examinations (MCQs).

Level 2 - Knows how: Context-based tests - knows how to use knowledge and skills. Assessments may include essays, oral examinations, MCQs, and laboratory books.

Level 3 - Shows how: A pre-registration trainee pharmacy technician is able to demonstrate that they can perform in a simulated environment or in real life. Assessments may include Objective Structured Clinical Examinations (OSCEs)/other observed assessments, simulated patient assessments, designing, conducting and reporting an experiment, dispensing tests and taking a patient history.

Level 4 – Does: Acting independently and consistently in a complex but defined situation. Evidence for this level is provided when a pre-registration trainee pharmacy technician demonstrates the learning outcomes in a complex, familiar or everyday situation repeatedly and reliably. Assessments may include OSCEs or other observed assessments and taking a patient history.

Level of study
The basis of the initial education and training for pharmacy technicians is that it is a vocational learning experience, combining learning and work. Courses must be designed and delivered at least at Level 3 in the National Qualifications Framework (England and Wales)/Level 6 in the Scottish Qualifications and Credit Framework.

Domains of study
The learning outcomes fall under four domains:

1. Person-centred care
2. Professionalism
3. Professional knowledge and skills
4. Collaboration

The domains and learning outcomes are not hierarchical and have equal importance.

1. Person-centred care

Pre-registration trainee pharmacy technicians will:

1. Involve, support and enable every person when making decisions about their health, care and wellbeing Does
2. Optimise a person’s medication to achieve the best possible outcomes Knows how
3. Listen to the person, understand their needs and what matters to them Does
4. Give the person all relevant information in a way they can understand, so they can make informed decisions and choices Does
5. Obtain relevant information from people, including patients and other healthcare professionals and use it appropriately
6. Recognise and value diversity, and respect cultural differences – make sure that every person is treated fairly whatever their values and beliefs
7. Adapt information and communication to meet the needs of particular audiences
8. Apply principles of information governance and ensure patient confidentiality
9. Effectively promote healthy lifestyles using available resources and evidence-based techniques
10. Be able provide public health advice and recommend recognised health screening or public health initiatives
11. Take action to safeguard people, particularly children and vulnerable adults

2. **Professionalism**

**Learning outcomes**

Pre-registration trainee pharmacy technicians will:

12. Apply professional judgement in the best interests of people  
13. Recognise and work within the limits of their knowledge and skills and refer to others when needed  
14. Respond effectively to complaints, incidents and errors and in a manner which demonstrates person-centred care  
15. Use information to take effective decisions  
16. Take personal responsibility for health and safety of themselves and others and follow up any concerns about the workplace which might put them at risk  
17. Recognise when their performance or the performance of others is putting people at risk and respond appropriately  
18. Raise concerns even when it is not easy to do so  
19. Act openly and honestly when things go wrong  
20. Use a variety of methods to regularly monitor and reflect on practice, skills and knowledge  
21. Effectively use feedback to develop professional practice  
22. Carry out a range of relevant continuing professional development (CPD) activities  
23. Reflect and act on feedback or concerns, thinking about what can be done to prevent something happening again

3. **Professional knowledge and skills**

**Learning outcomes**

Pre-registration trainee pharmacy technicians will:
25. Provide a safe, effective and responsive pharmacy service
26. Take personal responsibility for the legal, safe and efficient supply of medicines
27. Apply basic pharmacological principles to the use of medicines
28. Confirm the suitability of a person’s medicines for use and ensure sufficient supply
29. Accurately retrieve and reconcile information about a person’s medicines
30. Assess a person’s current supply of medication and order appropriate medicines and products
31. Accurately review a person’s medication to identify the medicines required
32. Order, receive, maintain and supply medicines and other pharmaceutical products safely, legally and effectively
33. Receive prescriptions and check for validity, safety and clarity, taking action to address identified deficiencies
34. Effectively use systems to support safe supply of medicines
35. Accurately assemble prescribed items
36. Apply pharmaceutical principles to the safe and effective formulation, preparation and packaging of medicines and products
37. Issue prescribed items safely and effectively and take action to address discrepancies
38. Undertake an accuracy check of dispensed medicines and products
39. Accurately perform pharmaceutical calculations to ensure safety of people
40. Ensure quality of ingredients to produce and supply safe and effective medicines and products
41. Recognise adverse drug reactions and interactions and respond appropriately
42. Safely and legally dispose of medicines and other pharmaceutical products
43. Respond appropriately to medical emergencies, including provision of first aid
44. Understands the importance of recording and learning from errors and near misses
45. Understand concepts of clinical governance and working effectively as part of multi-disciplinary teams
46. Participate in audit and quality improvement strategies and implement recommendations effectively

4. Collaboration

Learning outcomes

Pre-registration trainee pharmacy technicians will:
47. Demonstrate effective team working
48. Communicate and work effectively with members of the multi-disciplinary team
49. Check their own and others’ work effectively
50. Participate in the learning and development of others
51. Prioritise time and resources effectively to achieve objectives

Does
Does
Does
Does
Does
Part 2: Standards for IET course providers

Domain 1 – Selection and entry requirements

Standard 1.1: Selection processes must be open, clear, unbiased and compliant with relevant legislation.

Standard 1.2: Processes must be designed to identify applicants with the right attributes for training as a healthcare professional.

Standard 1.3: Entry requirements must ensure that applicants are fit to practise as trainees at the point of selection.

Criteria to meet these standards

1.1 Selection criteria must be explicit. They must include as a minimum:

- meeting specified English language requirements
- meeting specified numeracy requirements
- taking account of good character checks
- taking account of health checks

1.2 Applicants must be working in a pharmacy environment and be supervised by a pharmacist or pharmacy technician.

1.3 Selectors must apply the selection criteria consistently, in an unbiased way and in line with relevant legislation. They should be trained to do this and training should include equality, diversity and inclusion.

1.4 Applicants must be given the guidance they need to make an informed application.

Domain 2 – Equality and diversity

Standard 2: All aspects of pharmacy technician education and training must be based on principles of equality and diversity and meet the requirements of all relevant legislation.

Criteria to meet this standard

2.1 Equality and diversity must be embedded in course design and delivery.
2.2 Equality and diversity data must be used to inform course design and delivery and the pre-registration trainee pharmacy technician experience.

2.3 Reasonable adjustments must be made to course delivery and assessment to help pre-registration trainee pharmacy technicians with specific needs to meet the learning outcomes. Teaching, learning and assessment may be modified for this purpose but learning outcomes may not.

**Domain 3 – Management, resources and capacity**

*Standard 3: Courses must be planned and maintained through transparent processes which must show who is accountable for what at each stage of initial education and training. The education and training facilities, infrastructure, leadership, staffing and staff support must be sufficient to deliver the course.*

**Criteria to meet this standard**

3.1 All courses must be underpinned by a defined management plan which must include:

- a schedule of roles and responsibilities, both in learning/training environments and in the workplace
- lines of accountability, both in learning/training environments and in the workplace
- defined structures and processes to manage delivery
- processes for identifying and managing risk

3.2 There must be agreements in place outlining the roles and responsibilities of all those involved in delivering a course.

3.3 Learning agreements must be in place with the pre-registration trainee pharmacy technician in all learning/training environments. These must outline roles, responsibilities and lines of accountability.

3.4 All course providers must have pharmacy professionals involved in the design and the delivery of the course.

3.5 In all learning environments, there must be:

- appropriately qualified and experienced staff
- sufficient staff from relevant disciplines to deliver the course and support pre-registration trainee pharmacy technicians’ learning
- sufficient resources available to deliver the course
- facilities that are fit for purpose
- access to appropriate learning resources
3.6 All those involved in managing and delivering the course must understand their role and must be supported to carry out their work effectively.

3.7 Each pre-registration trainee pharmacy technician must be supported as a learner in the workplace and there must be mechanisms in place for liaising with course providers regularly about the progress of a pre-registration trainee pharmacy technician.

Domain 4 – Monitoring, review and evaluation

**Standard 4: The quality of courses must be monitored, reviewed and evaluated in a systematic and developmental way.**

**Criteria to meet this standard**

4.1 All relevant aspects of courses must be monitored, reviewed and evaluated systematically. When issues are identified they must be documented and addressed within agreed timescales.

4.2 There must be a quality management structure in place that sets out procedures for monitoring and evaluation. This must include who is responsible and timings for reporting, review and taking action where appropriate.

4.3 There must be procedures in place to monitor and evaluate the standard of teaching, learning and assessment to ensure that quality is maintained across all learning environments.

4.4 Course monitoring and review must take into account the external environment, especially pharmacy, to ensure that courses remain up-to-date as they are delivered.

4.5 Feedback to pre-registration trainee pharmacy technicians must be embedded in monitoring, review and evaluation processes.

Domain 5 – Course design and delivery

**Standard 5: Courses must develop the professional behaviours, required skills, knowledge and understanding to meet the outcomes in Part 1 of these standards through a coherent teaching and learning strategy. The design and delivery of training must be informed by stakeholder engagement and must ensure that trainees practise safely and effectively.**
Criteria to meet this standard

5.1 Courses must be designed and delivered through strategies which integrate knowledge, competence and work.

5.2 The GPhC’s *Standards for Pharmacy Professionals* must be embedded and used actively in all courses. This is to ensure that pre-registration trainee pharmacy technicians are aware of what will be expected of them when they are registered.

5.3 There must be a course teaching and learning strategy which sets out how trainees will achieve the outcomes in the first part of these standards.

5.4 Courses must be designed and delivered to develop the professional behaviours, skills, knowledge and understanding required to meet the learning outcomes in Part 1 of these standards.

5.5 Course providers must engage with a range of stakeholders, including patients, the public and employers, to inform the design and delivery of the course.

5.6 Courses must be updated when there are significant changes in practice to ensure they are current.

5.7 Pre-registration trainee pharmacy technicians must be supervised through agreed mechanisms in all learning environments, to ensure patient safety at all times.

5.8 Pre-registration trainee pharmacy technicians must undertake only tasks in which they are competent, or are learning under supervision to be competent, so that patient safety is not compromised.

5.9 Course regulations must be appropriate for a course that leads to professional registration. That is, they must prioritise professionalism, patient safety, and safe and effective practice.

5.10 All course providers and employers must have procedures to deal with concerns. Serious concerns that may affect a pre-registration trainee pharmacy technician’s suitability for future registration must be reported to the GPhC.

Domain 6 – Course assessment

**Standard 6: Courses must have an assessment strategy which assesses the professional behaviours, required skills, knowledge and understanding to meet the outcomes in Part 1 of these standards. The assessment strategy must assess whether a pre-registration trainee pharmacy technician’s practice is safe.**

Criteria to meet this standard
6.1 Courses must have an assessment strategy which ensures that assessment is robust, reliable and valid.

6.2 The assessment strategy must assess the learning outcomes in Part 1 of these standards. Methods used must be appropriate for what is being assessed; and teaching, learning and assessment must be aligned.

6.3 Assessment of competence must take place in the workplace.

6.4 Patient safety must be paramount at all times and the assessment strategy must assess whether a pre-registration trainee pharmacy technician is practising safely.

6.5 Monitoring systems must be in place in all learning environments. The systems must assess a pre-registration trainee pharmacy technician’s progress towards meeting the learning outcomes in Part 1 of these standards and must ensure that a pre-registration trainee pharmacy technician’s practice is safe at all times. Causes for concern must be addressed as soon as possible.

6.6 Agreements must be in place between course providers, the workplace and pre-registration trainee pharmacy technicians. These must describe roles and responsibilities in the assessment of pre-registration trainee pharmacy technicians.

6.7 Assessments must be carried out by appropriately trained and qualified people who are competent to assess the performance of pre-registration trainee pharmacy technicians.

6.8 There must be independent quality assurance of assessment processes.

6.9 Pre-registration trainee pharmacy technicians must receive appropriate and timely feedback on their performance to support their development as learners and professionals.

6.10 Assessment regulations must be appropriate for a course that leads to professional registration, that is they must prioritise professionalism, patient safety and safe and effective practice.

**Domain 7 – Pre-registration trainee pharmacy technician support and the learning experience**

*Standard 7: Pre-registration trainee pharmacy technicians must be supported in all learning environments to develop as learners and professionals during their initial education and training.*

*Criteria to meet this standard*
7.1 A range of mechanisms must be in place to support trainees to achieve the learning outcomes in Part 1 of these standards, including:

- induction
- effective supervision
- an appropriate and realistic workload
- personal and academic support
- time to learn
- access to resources

7.2 There must be mechanisms in place for pre-registration trainee pharmacy technicians to meet regularly with workplace colleagues to discuss and document their progress as learners.

7.3 Support must be available to pre-registration trainee pharmacy technicians relating to academic study, general welfare and career advice.

7.4 Pre-registration trainee pharmacy technicians must have access to pharmacists and/or pharmacy technicians who are able to act as role models and provide professional support and guidance.

7.5 Pre-registration trainee pharmacy technicians must have the opportunity to work in multi-disciplinary environments.

7.6 There must be clear procedures for pre-registration trainee pharmacy technicians to raise concerns. Any concerns must be dealt with promptly, with documented action taken where appropriate. Pre-registration trainee pharmacy technicians must be made aware of the GPhC’s guide to raising concerns about pharmacy education and training (https://www.pharmacyregulation.org/raising-concerns-about-pharmacy-education-and-training)

7.7 Everyone supporting pre-registration trainee pharmacy technicians must take into account the GPhC’s Guidance on tutoring for pharmacists and pharmacy technicians in their work.
Part 3: Changes to the criteria for registration as a pharmacy technician

Alongside developing revised IET standards for pharmacy technicians we have revisited the criteria we set for pharmacy technicians to be entered in the register. The criteria set out the route to and requirements for registration. Many of the requirements set out in the criteria are historical and were put in place when pharmacy technicians first became a registered profession in 2005 and need updating.

The criteria are in two parts. The first sets out the qualifications and work experience requirements for initial registration as a pharmacy technician with the GPhC. The second sets out the requirements for those wishing to return to registration as a pharmacy technician.

We are considering some changes to part one as a result of feedback we have received from stakeholders and to reflect Council’s commitment to outcomes focussed and proportionate regulation.

The changes we are considering are:

1. Pre-registration trainee pharmacy technicians will be able to train under the direction, supervision or guidance of a pharmacy technician or pharmacist. The current criteria include the requirement that pre-registration trainee pharmacy technicians must train under the direction, supervision or guidance of a pharmacist only. Now that pharmacy technicians are an established registrant group, we think that pre-registration trainee pharmacy technicians should be able to be supervised by the registrant group they aspire to join. This also takes into account that pharmacy technicians may train legitimately in pharmacy environments where a pharmacist may not be present.

2. Removing the two year work experience and set minimum hours requirements for the training period. The current criteria state that a pre-registration trainee pharmacy technician must undertake a minimum of two years’ work experience in the UK and a set minimum hours requirements for this work experience period. It may be the case that a trainee needs two years to complete their initial education and training (and the feedback we have received from training providers is that most will), but where a trainee is able to demonstrate they have met all learning outcomes fully in
less than two years, they should be allowed to do so, subject to their prior education
and experience being evaluate by the course provider.

3. **Removing the option that current or recently registered pharmacists in Great Britain or Northern Ireland are able to register as a pharmacy technician automatically.** Presently, current or recently registered pharmacists can automatically register as a pharmacy technician. Although there are many similarities between the professions, there are also differences and we do not think it appropriate that one healthcare professional can simply register as another without some independent assessment. We suggest that pharmacists wishing to register as pharmacy technicians should be required to complete the same initial education and training as pre-registration trainee pharmacy technicians, although they could apply to have their prior learning and experience recognised by the course provider.

We have included a question on these proposed changes as part of the consultation.

You can find a copy of our current criteria for registration as a pharmacy technician by clicking on this link: 
http://www.pharmacyregulation.org/sites/default/files/Registration%20criteria%20for%20pharmacy%20technicians%20Dec%202013.pdf
Consultation response form
Response to the consultation on IET standards for pharmacy technicians

If you want your response to stay confidential, please explain why you think the information you have given is confidential. We cannot give an assurance that confidentiality can be maintained in all circumstances.

☐ Please remove my name from my published response

Please tell us if you have any concerns about our publishing any part of your response:

Background questions
First, we would like to ask you for some background information. This will help us to understand the views of specific groups, individuals and organisations and will allow us to better respond to those views.

Are you responding:

☐ as an individual – please go to section A
☐ on behalf of an organisation – please go to section B
Section A - Responding as an individual

Please tell us your:

name:----------------------------------------------------------------------------------------------------------------------

address:----------------------------------------------------------------------------------------------------------------------
----------------------------------------------------------------------------------

e-mail:-----------------------------------------------------------------------------------------------------------------------

Where do you live?

☐ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ other (please give details)

Are you responding as:

☐ a member of the public
☐ a pharmacy professional – please go to section A1
☐ a pre-registration trainee pharmacy technician
☐ a pre-registration trainee pharmacist
☐ a pharmacy student
☐ other (please give details)

Section A1 - Pharmacy professionals

Are you:

☐ a pharmacy technician
☐ a pharmacist
Please choose the option below which best describes the area you mainly work in:

☐ community pharmacy
☐ hospital pharmacy
☐ primary care organisation
☐ pharmacy education and training
☐ pharmaceutical industry
☐ other (please give details)

Section B: Responding on behalf of an organisation

Please tell us your:

name:..............................................................................................................

job title:...........................................................................................................

organisation:..................................................................................................

address:...........................................................................................................

email:...............................................................................................................

a contact name for enquiries:...........................................................................

contact phone number:..................................................................................

Is your organisation a:

☐ pharmacy organisation
☐ non-pharmacy organisation
Please choose the option below which best describes your organisation:

- ☐ body or organisation representing professionals
- ☐ body or organisation representing patients or the public
- ☐ body or organisation representing a trade or industry
- ☐ community pharmacy
- ☐ corporate multiple pharmacy
- ☐ independent pharmacy
- ☐ NHS organisation or group
- ☐ pharmacy technician education and training provider
- ☐ other research, education or training organisation
- ☐ government department or organisation
- ☐ regulatory body
- ☐ other (please give details)
How we will use your responses

All information in responses, including personal information, may be subject to publication or disclosure in accordance with the access to information regimes (primarily the Freedom of Information Act 2000, the Data Protection Act 1998 and the Environmental Information Regulations 2004).

If you want your response to remain confidential, you should explain why you regard the information you have provided as confidential. However, we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the GPhC.

Your response to this consultation may be published in full or in a summary of responses. We will remove any individual names from responses to the consultation or quotes taken from them if these are published. Individual contributions will not be acknowledged unless specifically requested.

The GPhC is a data controller registered with the Information Commissioner’s Office. The GPhC makes use of personal data to support its work as the regulatory body for pharmacists, pharmacy technicians and retail pharmacy premises in Great Britain.

Data may be shared with third parties in pursuance of the GPhC’s statutory aims, objectives, powers and responsibilities under the Pharmacy Order 2010, the rules made under the order and other legislation.

Personal data may be processed for purposes including (but not limited to) updating the register, administering and maintaining registration, processing complaints, compiling statistics and keeping stakeholders updated with information about the GPhC.

Information may be passed to organisations with a legitimate interest including (but not limited to) other regulatory and enforcement authorities, NHS trusts, employers, Department of Health, universities and research institutions. Please note that the GPhC will not share your personal data on a commercial basis with any third party.
Consultation questions

We are particularly interested in your views on the following points, although we welcome your comments on any issues that you want to raise about the IET standards for pharmacy technicians.

Part 1: IET standards for pharmacy technicians – learning outcomes

Part 2: Standards for IET course providers

The standards focus on high quality care, of which safety is a critical element; this is core to the education and training of all pharmacy professionals. This underpinning principle is embedded throughout these standards.

The standards also reflect how some elements of the pharmacy technician role, which historically were seen as advanced practice, are now core to that role. This includes the ability to carry out accuracy checking; the requirement for newly qualified pharmacy technicians (like pharmacists) to be able to understand core safety concepts such as clinical and corporate governance, as well as audit; and their ability to work both within and across teams. The draft standards should also reflect improved links between providers and employers.

1. IET standards for pharmacy technicians – learning outcomes: Are these the right outcomes, at the right level?

2. Standards for IET course providers: Are these the right standards and criteria?
Part 3: Changes to the criteria for registration as a pharmacy technician

We also outlined changes in three particular areas:

*Pre-registration trainee pharmacy technicians will be able to train under the direction, supervision or guidance of a pharmacy technician or pharmacist.*

The current criteria include the requirement that pre-registration trainee pharmacy technicians must train under the direction, supervision or guidance of a pharmacist only. Now that pharmacy technicians are an established registrant group, we think that pre-registration trainee pharmacy technicians should be able to be supervised by the registrant group they aspire to join. This also takes into account that pharmacy technicians may train legitimately in pharmacy environments where a pharmacist may not be present.

**3. Do you have any comments about this proposed change and its potential impact?**

*We propose to remove the two year work experience and set minimum hours requirements for the training period.*

The current criteria state that a pre-registration trainee pharmacy technician must undertake a minimum of two years’ work experience in the UK and set minimum hours requirements for this work experience period. It may be the case that a trainee needs two years to complete their initial education and training (and the feedback we have received from training providers is that most will) but where trainees are able to demonstrate they have met all learning outcomes fully in less than two years, they should be allowed to do so, subject to their prior education and experience being evaluated by the course provider.

**4. Do you have any comments about this proposed change and its potential impact?**
Removing the option that current or recently registered pharmacists in Great Britain or Northern Ireland are able to register as a pharmacy technician automatically.

At present, current or recently registered pharmacists can automatically register as a pharmacy technician. Although there are many similarities between the professions, there are also differences and we do not think it appropriate that one healthcare professional can simply register as another without some independent assessment. We suggest that pharmacists wishing to register as pharmacy technicians should be required to complete the same initial education and training as pre-registration trainee pharmacy technicians, although they could apply to have their prior learning and experience recognised by the course provider.

5. Do you have any comments about this proposed change and its potential impact?

Equality analysis

We haven’t identified any areas where these standards or suggested changes to the criteria would discriminate against or unintentionally disadvantage any individuals or groups. However, we do know from our own analysis that the pharmacy technician workforce is different to the pharmacist workforce in terms of the representation of protected characteristics, for example the gender balance in the registrant population.

We would invite views on any aspect of our proposals which might have an impact, positive or negative in relation to equality. For example, we are that the change we are considering in relation to the two year work experience requirement may affect groups differently.

6. Do you think there is anything in the standards or suggested changes to the criteria for registration that disproportionately impacts any particular group over others?
Other comments

If you have any further comments, please add them here:
Equality monitoring

The General Pharmaceutical Council is committed to promoting equality, valuing diversity and being inclusive in all our work as a regulator, and ensuring that our equality duties are met. This equalities monitoring form will provide us with useful information to check that this happens.

Completing this equalities monitoring form is not mandatory and the information you provide here will be used purely for monitoring purposes.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male ☐</th>
<th>Female ☐</th>
<th>Other ☐</th>
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<tr>
<th>Sexual orientation</th>
<th>Heterosexual/Straight ☐</th>
<th>Gay woman/Lesbian ☐</th>
<th>Gay man ☐</th>
<th>Bisexual ☐</th>
<th>Other ☐</th>
<th>Prefer not to say ☐</th>
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Disability

Disability is defined in the Equality Act 2010 as “physical or mental impairment, which has a substantial and long term adverse effect on a person’s ability to carry out normal day to day activities”.

<table>
<thead>
<tr>
<th>Do you consider yourself disabled?</th>
<th>Yes ☐</th>
<th>No ☐</th>
<th>Prefer not to say ☐</th>
</tr>
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If yes, please give details:

<table>
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<tr>
<th>Age group</th>
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<td>16 - 24 years</td>
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<td>☐</td>
<td>35 - 44 years</td>
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<td>45 - 54 years</td>
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<td>65+ years</td>
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<td>25 - 34 years</td>
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<td>55 - 64 years</td>
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## What is your ethnic group?
Choose the appropriate box to indicate your cultural background.

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<td>☐ Black Caribbean</td>
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<td>☐ Irish</td>
<td>☐ Black African</td>
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<tr>
<td>☐ Other white background (please give details in box below)</td>
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<td>☐ Gypsy or Irish Traveller</td>
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<td>☐ White &amp; black Caribbean</td>
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<td>☐ White &amp; black African</td>
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<td>☐ White &amp; Asian</td>
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<td>☐ Other mixed background (please give details in box below)</td>
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<td>Please give more information here:</td>
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### Religion

- ☐ No religion
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh

- ☐ Any other religion
- ☐ Prefer not to say
Public business

Standards for Pharmacy Professionals

Purpose
To present to Council updated Standards for Pharmacy Professionals which were agreed at the meeting on 13 October 2016, but which include further minor drafting amendments.

Recommendations
Council is asked to note agreed Standards for Pharmacy Professionals and associated equality impact assessment which incorporate a number of minor drafting amendments.

1. Introduction
1.1 Council has responsibility, under Article 48 of the Pharmacy Order, for setting standards relating to the conduct, ethics and performance of pharmacists and pharmacy technicians.

1.2 At the end of 2014 we announced a review of the current standards and a lengthy consultation and engagement process was undertaken, leading to the development of a new set of draft standards for pharmacy professionals.

1.3 At 13 October 2016 meeting, Council was asked to approve the new standards and to agree the date for the standards to come into effect.

2. Standards for pharmacy professionals
2.1 At the October meeting, Council agreed the new standards subject to a number of minor drafting changes which it asked staff to consider.

2.2 Council agreed formally that responsibility for signing off the final version of the standards was to be delegated to Chair of Council and that the final version, incorporating drafting changes, would be circulated.

2.3 The Chair subsequently approved these minor drafting changes and a copy of the revised standards is attached at Annex A. Council should note that, as per its instructions, only minor drafting changes were made.

2.4 It should also be noted that the consultation planned on guidance on personal values and beliefs will enable people to provide further comment on
the relevant examples under Standards 1 (requiring pharmacy professionals to provide person-centred care). Council will be provided with feedback on this aspect of the consultation on guidance in advance of the standards for pharmacy professionals coming into force.

3. **Equality and diversity implications**

3.1 Council has previously considered a full equality impact assessment consistent with our responsibilities as set out in the Equalities Act 2010. The minor drafting amendments to the standards have not identified any additional areas to be included in the assessment. We have, made some minor changes to the equality impact assessment to incorporate feedback from Council at the meeting in October. The final version of the equality impact assessment is attached in Annex B.

4. **Communications**

4.1 Council has previously noted a detailed plan, setting out all communications and engagement activities that we are planning to undertake over the coming year, to launch and implement the standards.

4.2 By noting the final version of the standards in the appendix stakeholders, including members of the public, registrants and interested organisations, can access the final version of the standards due to be introduced formally in May 2017.

5. **Resource implications**

5.1 The resource implications for this work, including communication and implementation of the new standards, have been accounted for in existing budgets.

6. **Risk implications**

6.1 There are no additional risk implications identified.

**Recommendations**

Council is asked to note agreed Standards for Pharmacy Professionals, which incorporate a number of minor drafting amendments.

*Laura McClintock, Head of Policy and Standards*
*General Pharmaceutical Council*
*Laura.McClintock@pharmacyregulation.org*
*Tel 020 3713 8079*

03 November 2016
Standards for pharmacy professionals

May 2017
Standards for pharmacy professionals

About us
The General Pharmaceutical Council regulates pharmacists, pharmacy technicians and registered pharmacies in Great Britain.

What we do
Our main work includes:

- setting standards for the education and training of pharmacists and pharmacy technicians, and approving and accrediting their qualifications and training
- maintaining a register of pharmacists, pharmacy technicians and pharmacies
- setting the standards of conduct and performance that pharmacy professionals have to meet throughout their careers
- setting the standards of continuing professional development that pharmacy professionals have to achieve throughout their careers
- investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public
- setting standards for registered pharmacies which require them to provide a safe and effective service to patients
- inspecting registered pharmacies to check if they are meeting our standards

Introduction

1 ‘Pharmacy professionals’ (pharmacists and pharmacy technicians) play a vital role in delivering care and helping people to maintain and improve their health, safety and wellbeing. The professionalism they demonstrate is central to maintaining trust and confidence in pharmacy.

2 Patients and the public have a right to expect safe and effective care from pharmacy professionals. We believe it is the attitudes and behaviours of pharmacy professionals in their day-to-day work which make the most significant contributions to the quality of care, of which safety is a vital part.

3 The standards for pharmacy professionals describe how safe and effective care is delivered through ‘person-centred’ professionalism. The standards are a statement of what people expect from pharmacy professionals, and also reflect what pharmacy professionals have told us they expect of themselves and their colleagues.

4 At the heart of the standards is the principle that every person must be treated as an individual. Pharmacy professionals have an important role in involving, supporting and enabling people to make decisions about their health, safety and wellbeing. For example, what is important to one person managing their short or long-term condition may not be important to another.
The standards for pharmacy professionals

5 There are nine standards that every pharmacy professional is accountable for meeting. The standards apply to all pharmacists and pharmacy technicians. We know that pharmacy professionals practise in a number of sectors and settings and may use different ways to communicate with the people they provide care to. The standards apply whatever their form of practice. And even when pharmacy professionals do not provide care directly to patients and the public, their practice can indirectly have an impact on the safe and effective care that patients and the public receive, and on the confidence of members of the public in pharmacy as a whole.

6 The standards need to be met at all times, not only during working hours. This is because the attitudes and behaviours of professionals outside of work can affect the trust and confidence of patients and the public in pharmacy professionals.

7 The meaning of each of the standards is explained, and there are examples of the types of attitudes and behaviours that pharmacy professionals should demonstrate. The examples may not apply in all situations.

8 The standards include the term ‘person-centred care’ and refer to a ‘person’ throughout. This means ‘the person receiving care’. The term may also apply to carers or patients’ representatives depending on the situation.

The standards and pharmacy students and trainees

9 The standards for pharmacy professionals are relevant to all pharmacy students and trainees while they are on their journey towards registration and practice. The standards explain the knowledge, attitudes and behaviours that will be expected of students and trainees if they apply to join the register.

10 They should be interpreted in the context of education and training and used as a tool to prepare students and trainees for registration as a pharmacy professional.

11 Pharmacy students and trainees should consider the standards as they move closer to registration and professional practice, and should read them alongside other relevant documents that are provided by initial education and training providers.
The standards and registration

12 The standards are designed to reflect what it means to be a pharmacy professional. They are also at the heart of initial education and training, registration and renewal as a pharmacy professional, and continuing fitness to remain registered.

Applying the standards

13 Pharmacy professionals are personally accountable for meeting the standards and must be able to justify the decisions they make.

14 We expect pharmacy professionals to consider these standards, their legal duties and any relevant guidance when making decisions.

15 The standards and supporting explanations do not list the legal duties pharmacy professionals have, as all pharmacy professionals must keep to the relevant laws. Relevant guidance is published by a number of organisations, including professional leadership bodies, other regulators, the NHS, National Institute for Health and Care Excellence and Scottish Intercollegiate Guidelines Network, as well as by the GPhC.

16 There will be times when pharmacy professionals are faced with conflicting legal and professional responsibilities. Or they may be faced with complex situations that mean they have to balance competing priorities. The standards provide a framework to help them when making professional judgements. Pharmacy professionals must work in partnership with everyone involved, and make sure the person they are providing care to is their first priority.
Standards for pharmacy professionals

All pharmacy professionals contribute to delivering and improving the health, safety and wellbeing of patients and the public. Professionalism and safe and effective practice are central to that role.

Pharmacy professionals must:
1. provide person-centred care
2. work in partnership with others
3. communicate effectively
4. maintain, develop and use their professional knowledge and skills
5. exercise professional judgement
6. behave in a professional manner
7. respect and maintain the person’s privacy and confidentiality
8. speak up when they have concerns or when things go wrong
9. demonstrate leadership
Standard 1

Pharmacy professionals must provide person-centred care

Applying the standard

Every person is an individual with their own values, needs and concerns. Person-centred care is delivered when pharmacy professionals understand what is important to the individual and then adapt the care to meet their needs – making the care of the person their first priority. All pharmacy professionals can demonstrate ‘person-centredness’, whether or not they provide care directly, by thinking about the impact their decisions have on people. There are a number of ways to meet this standard, and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- obtain consent to provide care and pharmacy services
- involve, support and enable every person when making decisions about their health, care and wellbeing
- listen to the person and understand their needs and what matters to them
- give the person all relevant information in a way they can understand, so they can make informed decisions and choices
- consider the impact of their practice whether or not they provide care directly
- respect and safeguard the person’s dignity
- recognise and value diversity, and respect cultural differences – making sure that every person is treated fairly whatever their values and beliefs
- recognise their own values and beliefs but do not impose them on other people
- take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs
- make the best use of the resources available
Standard 2

Pharmacy professionals must work in partnership with others

Applying the standard

A person’s health, safety and wellbeing are dependent on pharmacy professionals working in partnership with others, where everyone is contributing towards providing the person with the care they need. This includes the person and will also include other healthcare professionals and teams. It may also include carers, relatives and professionals in other settings – such as social workers and public health officials. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- work with the person receiving care
- identify and work with the individuals and teams who are involved in the person’s care
- contact, involve and work with the relevant local and national organisations
- demonstrate effective team working
- adapt their communication to bring about effective partnership working
- take action to safeguard people, particularly children and vulnerable adults
- make and use records of the care provided
- work with others to make sure there is continuity of care for the person concerned
Standard 3

Pharmacy professionals must communicate effectively

Applying the standard

Communication can take many forms and happens in different ways. Effective communication is essential to the delivery of person-centred care and to working in partnership with others. It helps people to be involved in decisions about their health, safety and wellbeing. Communication is more than giving a person information, asking questions and listening. It is the exchange of information between people. Body language, tone of voice and the words pharmacy professionals use all contribute to effective communication. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- adapt their communication to meet the needs of the person they are communicating with
- overcome barriers to communication
- ask questions and listen carefully to the responses, to understand the person’s needs and come to a shared decision about the care they provide
- listen actively and respond to the information they receive in a timely manner
- check the person has understood the information they have been given
- communicate effectively with others involved in the care of the person
Standard 4

Pharmacy professionals must maintain, develop and use their professional knowledge and skills

Applying the standard

People receive safe and effective care when pharmacy professionals reflect on the application of their knowledge and skills and keep them up-to-date, including using evidence in their decision making. A pharmacy professional’s knowledge and skills must develop over the course of their career to reflect the changing nature of healthcare, the population they provide care to and the roles they carry out. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- recognise and work within the limits of their knowledge and skills, and refer to others when needed
- use their skills and knowledge, including up-to-date evidence, to deliver care and improve the quality of care they provide
- carry out a range of continuing professional development (CPD) activities relevant to their practice
- record their development activities to demonstrate that their knowledge and skills are up to date
- use a variety of methods to regularly monitor and reflect on their practice, skills and knowledge
Standard 5

Pharmacy professionals must use their professional judgement

Applying the standard

People expect pharmacy professionals to use their professional judgement so that they deliver safe and effective care. Professional judgement may include balancing the needs of individuals with the needs of society as a whole. It can also include managing complex legal and professional responsibilities and working with the person to understand and decide together what the right thing is for them – particularly if those responsibilities appear to conflict. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- make the care of the person their first concern and act in their best interests
- use their judgement to make clinical and professional decisions with the person or others
- have the information they need to provide appropriate care
- declare any personal or professional interests and manage these professionally
- practise only when fit to do so
- recognise the limits of their competence
- consider and manage appropriately any personal or organisational goals, incentives or targets and make sure the care they provide reflects the needs of the person
**Standard 6**

**Pharmacy professionals must behave in a professional manner**

*Applying the standard*

People expect pharmacy professionals to behave professionally. This is essential to maintaining trust and confidence in pharmacy. Behaving professionally is not limited to the working day, or face-to-face interactions. The privilege of being a pharmacist or pharmacy technician, and the importance of maintaining confidence in the professions, call for appropriate behaviour at all times. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- are polite and considerate
- are trustworthy and act with honesty and integrity
- show empathy and compassion
- treat people with respect and safeguard their dignity
- maintain appropriate personal and professional boundaries with the people they provide care to and with others
Standard 7
Pharmacy professionals must respect and maintain a person’s confidentiality and privacy

Applying the standard

People trust that their confidentiality and privacy will be maintained by pharmacy professionals, whether in a healthcare setting – such as a hospital, primary care or community pharmacy setting – in person, or online. Maintaining confidentiality is a vital part of the relationship between a pharmacy professional and the person seeking care. People may be reluctant to ask for care if they believe their information may not be kept confidential. The principles of confidentiality still apply after a person’s death. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- understand the importance of managing information responsibly and securely, and apply this to their practice
- reflect on their environment and take steps to maintain the person’s privacy and confidentiality
- do not discuss information that can identify the person when the discussions can be overheard or seen by others not involved in their care
- ensure that everyone in the team understands the need to maintain a person’s privacy and confidentiality
- work in partnership with the person when considering whether to share their information, except where this would not be appropriate
Standard 8

Pharmacy professionals must speak up when they have concerns or when things go wrong

Applying the standard

The quality of care that people receive is improved when pharmacy professionals learn from feedback and incidents, and challenge poor practice and behaviours. This includes speaking up when they have concerns. At the heart of this standard is the requirement to be candid with the person concerned and with colleagues and employers. This is usually called the ‘duty of candour’ – which means being honest when things go wrong. There are a number of ways to meet this standard and below are examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- promote and encourage a culture of learning and improvement
- challenge poor practice and behaviours
- raise a concern, even when it is not easy to do so
- promptly tell their employer and all relevant authorities (including the GPhC) about concerns they may have
- support people who raise concerns and provide feedback
- are open and honest when things go wrong
- say sorry, provide an explanation and put things right when things go wrong
- reflect on feedback or concerns, taking action as appropriate and thinking about what can be done to prevent the same thing happening again
- improve the quality of care and pharmacy practice by learning from feedback and when things go wrong
Standard 9
Pharmacy professionals must demonstrate leadership

Applying the standard

Every pharmacy professional can demonstrate leadership, whatever their role. Leadership includes taking responsibility for their actions and leading by example. Wherever a pharmacy professional practises, they must provide leadership to the people they work with and to others. There are a number of ways to meet this standard and below are some examples of the attitudes and behaviours expected.

People receive safe and effective care when pharmacy professionals:

- take responsibility for their practice and demonstrate leadership to the people they work with
- assess the risks in the care they provide and do everything they can to keep these risks as low as possible
- contribute to the education, training and development of the team or of others
- delegate tasks only to people who are competent and appropriately trained or are in training, and exercise proper oversight
- do not abuse their position or set out to influence others to abuse theirs
- lead by example, in particular to those who are working towards registration as a pharmacy professional
1. Aims and purpose of the project/policy

The aim of the review is to produce revised standards for pharmacy professionals, through an extensive programme of engagement, that apply to all pharmacists and pharmacy technicians, at all times, whatever their scope of practice.

The aim of the standards is to explain the attitudes and behaviours that must be demonstrated by pharmacy professionals so that patients and the public receive safe and effective care, and can have trust and confidence in pharmacy.

The standards have been revised based on what we have heard and learnt through our regulatory work, such as the discussion paper on patient-centred professionalism, the IPSOS MORI research on public perceptions of pharmacy, and the evaluation of our approach to modernising pharmacy regulation.

The standards must take account of the new and changing roles for pharmacy professionals and healthcare more widely and be fit for purpose for the future. The standards must support a culture of professionalism, and be accessible to a range of audiences, including patients and the public, and pharmacy professionals.
2. Review available information and/or data

The draft standards, once approved, will apply to all pharmacists and pharmacy technicians.

The current registration equality data (as of 6 September 2016):

- Number of Registrants:
  - 77,291 registered pharmacists and pharmacy technicians
  - 54,054 pharmacists
  - 23,237 pharmacy Technicians

- Gender Profiles:
  - Females: 53,661
  - Males: 23,623
  - Unknown: 7

- Ethnicity Profile:
  - Asian: 20,591
  - Black: 3,633
  - Mixed: 409
  - Not Supplied/Unknown: 6,246
  - Other: 1,509
  - White: 44,856

- Age Profile:
  - 20-29 Years of Age: 16,743
  - 30-39 Years of Age: 23,797
  - 40-49 Years of Age: 17,592
  - 50-59 Years of Age: 14,083
  - 60-74 Years of Age: 4,777
  - +75 Years of Age: 188
  - Unknown: 111

- Disability Profile:
  - Disabled: 268
  - Not Disabled: 34,755
  - Unknown: 42,268

Note: We are seeking to extend the categories to include 7 protected characteristics in the future.

Our current standards were agreed by our council in June 2010. During the six years they have been in use, there have been many changes in pharmacy, and healthcare more widely. Pharmacy professionals are providing a greater range of services, in new and innovative ways, and are working in new areas.

In October 2014 we announced the review of the standards of conduct, ethics and performance.

In developing the draft standards we have drawn on information and feedback received over the previous five years as part of our ongoing work. There have been clear statements from ministers across Great Britain about the importance of further unlocking the potential and capacity of pharmacy professionals, including in the Scottish Government’s report, A Prescription for Excellence, and NHS England’s Pharmacy call to action. In addition we have attempted to embed learning from the inquiries into Mid Staffordshire NHS Foundation Trust, the Trusted to
Care report into care at Abertawe Bro Morgannwg University Health Board, and the inquiry into the Vale of Leven hospital. These all highlight failures of care and circumstances where clinicians and those providing care have failed to show professionalism.

We published a discussion paper on 24 April 2015 for nine weeks to help us understand what is important to our stakeholders when they think about patient-centred professionalism in pharmacy. The feedback from which has been used extensively in the development of our draft standards.

We developed a deliberative process which brought together members of the public from different backgrounds and lifestyles to debate issues over an extended period. Deliberative research was chosen because it would allow participants time and space to understand the issues relating to public and patient expectations.

We heard from patients and the public, pharmacy professionals, trainees and students, as well as a range of pharmacy organisations across Great Britain.

We set up specific patient and public focus groups across England, Scotland and Wales to ask questions about their expectations of pharmacy professionals.

We held three half-day workshops in London, Cardiff and Edinburgh during May 2015.

In total 43 participants attended. Participants were recruited by Community Research to be broadly representative of the British population as a whole, with reference to the following criteria:

- Gender
- Age group
- Ethnic background
- Working status
- Social grade
- Family composition (i.e. whether they have dependent children in the household)
- Disability and recent health experience

Excellent feedback was provided during these events, although there were no specific equalities issues raised.

(Following the initial draft of this EIA the formal consultation on the draft standards were undertaken from 4 April 2016 to 27 June 2016 the outcome of which is documented below).

### 3. Screening for relevance to equality and diversity issues

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<td>Race</td>
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<td>Gender reassignment</td>
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</table>
4. From the answers supplied, decide what further work needs to be undertaken if the proposal impacts upon diversity or equality issues.

A formal consultation was undertaken from 4 April 2016 to 27 June 2016.

We believe the standards for pharmacy professionals will have positive implications for people, support the general principles of promoting equality and mitigate the risk of bias or discrimination. Our focus, reflected in the standards, is on delivering person centred care, and understanding a person’s values and needs when providing care.

Specific examples considered below:

Draft standard 1: *Pharmacy professionals must provide person-centred care* refers to recognising and valuing diversity and respecting cultural differences, making sure that every person is treated fairly whatever their values and beliefs. It emphasises the importance of pharmacy professionals recognising their own values and beliefs but not imposing them on other people.

Draft standard 3: *Pharmacy professionals must communicate effectively* highlights the need for pharmacy professionals to adapt their communication to meet the needs of the person they are communicating with.

We also highlighted in the consultation areas where further guidance might be needed where there could be equalities implications. These include:

- Consent
- Confidentiality
- Maintaining sexual boundaries
  Balancing personal beliefs and the care of the patients

We see the promotion of guidance in these areas as likely, if anything, to have a net positive impact on those who may be at risk from discrimination.

In order to better understand any potential implications, we included a specific question as part of the consultation:

- *Are there any aspects of the standards that could have a negative impact on patients, members of the*
5. Consultation / Involvement

Standards for pharmacy professionals consultation – 4 April 2016 to 27 June 2016

A wide variety of communication channels were used to maximise participation in the consultation across a diverse range of stakeholder groups, and both general and targeted engagement were used to reach all potential audiences. Further information about our communication and engagement activities can be found in our engagement and communications report.

A total of 1,295 responses were received from individuals and organisations through our online response form, email and by post. In addition, we discussed the standards in 35 events held across Great Britain, engaging with 378 patients and members of the public and 1,279 pharmacy professionals. The analysis of responses can be found in here.

6. Date and method of consultation

Please see the analysis of responses.

7. Give a brief summary of the results of the consultation / involvement? How have these affected the proposal?

In total, 1,295 written responses to the consultation were analysed. Alongside this, we have analysed the responses from face to face meetings and events.

In summary:

i. 97% of respondents found the introduction to be clear

ii. 93% of respondents agreed with our approach to students and trainees

iii. 95% of respondents thought the standards were clear

iv. 96% of respondents thought the ‘applying the standards’ section was helpful and approx. 94% thought this section was clear and easy to understand

v. 90% of respondents agreed with our approach to values and personal beliefs
vi. 12% of respondents believed that the standards could have a negative impact on patients, members of the public, pharmacists, pharmacy technicians, or any other groups.

We have made a number of drafting changes in light of the responses we received. However, we do not propose any changes to the overall approach to the standards for pharmacy professionals.

Respondents raised a range of issues, broadly in six categories:

i. Observations about the generic nature of the standards and requests for detailed guidance

ii. The application of the standards to non-patient facing roles

iii. Values and personal beliefs

iv. What the standards mean for students and trainees

v. The role of owners and superintendents, and workplace pressures

vi. Clarity about the relationship between the standards, and fitness to practise and continuing fitness to practise

In the consultation under the standard ‘Pharmacy professionals must provide person-centred care’, we said:

People receive safe and effective care when pharmacy professionals:

i. Recognise their own values and beliefs but do not impose them on other people

ii. Tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers

Most respondents, around 90%, agreed with the approach proposed. Some of the pharmacy organisations who commented on this matter welcomed the approach as it confirms current practice.

The majority of those who commented in this section were of the view that pharmacy professionals should not be able to refuse services based on account of their values and personal beliefs. This, it was argued, would contradict the principle of providing person centred care. This sentiment was also echoed in the pharmacy user engagement events as well as some of the responses from organisations representing patients and the public.

Reflecting on what we have heard, and further considering case law and the requirements of the Human Rights Act 1998 and the European Convention on Human Rights and Equality Act 2010, we propose a change to the wording we consulted on.
We intend to keep the standard as drafted but to change the example given under the standard to provide greater clarity about our commitment to person centered professionalism. This will reinforce our desire to strike an appropriate balance between the needs of the person to receive safe and effective care and the need to avoid discrimination on the basis of values and personal beliefs of individual pharmacy professionals.

In line with our strategy to promote a culture of professionalism and our focus on person-centred care, we propose making clear that a pharmacy professional’s values and personal beliefs are not an acceptable reason to discriminate against the people in their care, whether because of their protected characteristics or because of the type of services they require. Every person using pharmacy services must have confidence that they will receive high quality care. Pharmacy professionals must therefore take responsibility for ensuring that person-centred care is not compromised by their beliefs, and not put themselves in the position where people are unable to access the care they require.

We propose changing the wording of the example given under Standard 1 to “take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs” which reflects the paragraph set out above.

We will also be confirming our intention to develop guidance on this subject. As part of the development process we will: consult on the updated wording proposed as set out in the paragraph above; explore this issue in more detail to ensure future guidance reflects accurately both the needs of patients and the public, the rights of registrants, as well as our expectations. In summary, it is important that future guidance achieves the aim of supporting registrants to meet the standard and is consistent with the legal framework.

8. Full impact assessment

   Explain the potential impact (whether intended or unintended, positive or adverse) of the proposal on individuals or groups on account of:

   **Race** – consider impact on people of different ethnic groups, nationalities, Gypsies, Travellers, languages etc.

   No adverse impact identified

   **Gender reassignment** – consider impact on transsexual and transgender people including bullying, harassment and discrimination issues not least ensuring privacy of data to avoid disclosure of gender history.

   The Gender Identity Research and Education Society (GIRES) expressed the view that person-centred care “should prevent the possibility for pharmacists to pass a person on to someone else because they don’t ‘approve’ of the use of particular products for particular people, owing to their
We believe that issues raised here have been mitigated by the drafting changes identified above and the draft standards themselves.

**Sex** – consider impact on men and women; working arrangements, for example, part-time, shift working, caring responsibilities.

No adverse impact identified

**Disability** – consider environmental, social and attitudinal barriers.

No adverse impact identified

**Marriage or Civil Partnership** – consider impact on married people or people in a civil partnership, young or old.

No adverse impact identified

**Age** – consider impact on people of different ages such as young or old.

No adverse impact identified

**Religion or belief** – consider impact on people with different religions or beliefs, or none.

Most respondents to our consultation (90%) agreed with the approach consulted on as did some of the pharmacy organisations who commented on this matter as it confirms current practice.

However the majority of those who commented in this section were of the view that pharmacy professionals should not be able to refuse services based on account of their personal beliefs. This, it was argued, would contradict the principle of providing person centred care. This sentiment was also echoed in the pharmacy user engagement events as well as some of the responses from organisations representing patients and the public.

In addition, the Patient Centred and Equality Group proposed that discrimination and stigma could have a greater emphasis and raised concern that a pharmacy professional’s values and beliefs “could be used as an excuse not to provide an evidence based service”, such as take home methadone treatment. They also proposed that, “a service may be provided but individuals can still be treated differently. It needs to be clear that pharmacists should not make value judgments about [a] patient’s current or previous lifestyle.”

Some of those who agreed with the proposed approach set out in the GPhC consultation document emphasised that provisions for alternative ways of accessing care or a service would have to be made.

There was also a view expressed that referring to another service provider in itself could be against a pharmacy professional’s values and beliefs. The Christians in Pharmacy Network highlighted in referencing to supplying abortifacients, Emergency Hormonal Contraception and drugs for assisted suicide that “the strongly held moral convictions of the pharmacy practitioner may prevent them, in good conscience, from actively recommending another source of supply.” Furthermore, it was said that refusing to provide a service was likely to have a detrimental impact
on the pharmacy professional as it would likely affect their employment opportunities.

We believe that the detailed examples expressed here should be explored as part of the development of our consultation on guidance to ensure that all relevant issues are explored appropriately and in detail so that the guidance supports registrant in meeting the standards.

**Sexual Orientation** – consider impact on bixexual, gay, heterosexual or lesbian.

The National LGB&T Partnership highlighted that an “array of diverse examples would ensure that a greater variety of possible situations are considered, and needs subsequently more likely to be met.” To demonstrate how pharmacy professionals could provide person centred care, they proposed examples such as, “times where patients come in with same-sex partners, where patients have English as their second language, and where LGBT people ask for guidance around, or disclose they are self-medicating, [and] prescriptions such as hormones and PrEP”.

We believe that issues raised here have been mitigated by the drafting changes identified above and the draft standards themselves and guidance will allow greater support for those who need it.

**Pregnancy or Maternity** – consider impact on pregnant women and those on maternity leave.

No adverse impact identified

**Welsh Language Scheme** – consider the linguistic consequences. Contact our scheme manager and Director for Wales for further advice.

The standards will be translated into Welsh for Welsh speaking public.

No adverse impact identified

**Other Issues**

n/a

9. Monitoring

a) How will the implementation of the proposal be monitored and by whom?

The areas we have identified that may have an impact on individuals or groups will require additional guidance to support the implementation of the Standards. Guidance on balancing personal beliefs and the care of patients will be consulted on, the outcomes of which will be taken into account in the final versions and reviewed periodically.

b) How will the results of monitoring be used to develop this proposal and its practices?

What we have heard as a result of the consultation will develop the proposal further and it will be reviewed every 3-5 years

c) What is the timetable for monitoring, with dates?

The standards will be reviewed every 3-5 years.
Presently guidance on balancing personal beliefs and the care of patients is timetabled to be consulted around mid November for 8 weeks.
Public business

2016/17 recruitment of the Appointments Committee Chair

Purpose
To set out plans for the upcoming recruitment process to replace the current Appointments Committee chair, and to approve amendments to the relevant procedure

Recommendations
The Council is asked
(a) to note the plans for the forthcoming replacement of the chair of the Appointments committee set out below; and
(b) to agree to amend the standard procedure for appointing the chair and members of the Appointments Committee to:
   i. delegate authority to the panel to appoint the Chair, as well as the members, of the Appointments Committee
   ii. delegate authority to the panel to amend the recruitment process if necessary

1. Introduction
1.1 The final term of office of the current chair of the Appointments Committee (AC) ends on 31 July 2017. The recruitment process for her replacement will need to start before the end of the year; accordingly, Council agreed an updated role and remit for the committee and its chair in July (appendix 1).
1.2 At its meeting in October, the Remuneration Committee agreed the level of remuneration for the role and a mechanism for reviewing that if necessary.

2. Standard procedure
2.1 The current procedure for appointment of the AC chair and members (appendix 2), which is due for review, is generally fit for purpose and there are only two proposed amendments.
2.2 Delegation of authority to the panel to appoint the Chair
Paras 3.4.8-9 currently read:
3.4.8 When selecting the Chair of the Appointments Committee the panel\(^1\) will propose a candidate to the Council. The Council will appoint the Chair of the Appointments Committee.

3.4.9 When selecting members of the Appointments Committee the Council delegates authority to the panel\(^1\) to select and appoint candidates.

2.3 We would like to propose that the Council delegate authority to the panel to appoint the chair, as well as the members, of the AC.

2.4 There are various reasons for proposing this:

i. Deferring the appointment for approval by the Council at a meeting will delay the appointment process, potentially considerably, and could be considered unfair to the candidates, who could be kept waiting for some time. It also risks the preferred candidate considering or accepting other conflicting offers in the meantime.

ii. Appointment of the chair of the Board of Assessors, and of the chair of the Fitness to Practise Committees, is delegated by Council to the relevant panel, so this would bring the three policies into line.

iii. As a matter of principle it can be argued that if the Council is content to delegate the identification of the preferred candidate to the panel, it should take the final step and delegate the making of the appointment, there being no appropriate reason why the Council as a whole would or should want to intervene to effectively change the outcome of a soundly designed process in which it ought to be able to place confidence.

2.5 *Delegation of authority to the panel to amend the recruitment process if necessary*

We would also like to propose that the panel be given authority to amend the recruitment process if necessary. This is to avoid significant delays in seeking approval for minor or inconsequential deviations from the process as described. Without this there is the potential for an appointment not to be made in time.

3. **2016/17 plans**

3.1 Following internal discussions, including with the Chair of Council, the executive has planned a recruitment timetable and process, in line with the standard procedure for appointment of the AC chair and members (see appendix 2 and section 2 above), that involves:

\(^1\) the panel comprises the Chair of Council, one lay and one registrant Council member, and an independent assessor
i. use of an executive search agency to identify, assess and interview candidates before producing a draft shortlist, and

ii. appointment of a panel chaired by the Chair of Council, with one lay and one registrant Council member and an independent assessor, to agree and interview the shortlisted candidates, and make the appointment (subject to Council’s decision on delegation, above).

3.2 Following a competitive procurement process, the executive is currently finalising an agreement with an executive search agency to act as our ‘preferred supplier’ for future senior appointments. The intention is that this agency will be used for the AC chair recruitment process also.

4. **Equality and diversity implications**

4.1 As explained in section 2 above, the proposed alterations to the standard procedure would seem fairer for candidates, who would not be kept waiting for the next Council meeting.

4.2 The process will benefit from the learning and work done in regard to enhancing diversity in the recent statutory committee recruitment, and from the extensive, cross-sectoral reach that the search agency can offer.

4.3 We will work with the agency and the panel to ensure we attract candidates from as diverse a range of backgrounds as possible, and do not unfairly disadvantage anyone; the agency will be instructed to prioritise this when planning its search and advertisement methodology.

4.4 We have considered the impact of this procedure in respect of all the protected characteristics. We have not identified any negative impact arising from the suggested process, and our plans to run an inclusive campaign will hopefully have a positive impact.

5. **Communications**

5.1 Once agreed, the process will be communicated to Appointments and Statutory Committee members, and will be detailed in the recruitment information pack.

6. **Resource implications**

6.1 The cost of the recruitment, including the agency fee, has been included in the 2017/18 budget.

6.2 No negative resource implications identified. The proposed amendments to the standard procedure will save time by shortening the appointment process.
7. **Risk implications**

7.1 The ability and credibility of the post holder is key to ensuring that the statutory committees produce robust, high quality outcomes, which in turn is vitally important if the Council is to fulfil its statutory functions. The appointment process needs to enable us to recruit a candidate of sufficient calibre and aptitude to fulfil this role, while fulfilling the expectations of Council and our stakeholders in regard to fairness and transparency.

7.2 As mentioned above, retention of the power to approve appointment by the Council creates a potentially significant delay which risks the candidate considering other conflicting offers in the meantime.

7.3 As above, if the panel does not have authority to amend the recruitment process, an unforeseen event mid-flow could potentially delay the process and lead to us failing to appoint in time.

7.4 The quality of the appointment is of great importance to the Council as the individual plays a key role in ensuring the quality of our statutory committee outcomes.

**Recommendations**

The Council is asked

(a) to note the plans for the forthcoming replacement of the chair of the Appointments committee set out above; and

(b) to agree to amend the standard procedure for appointing the chair and members of the Appointments Committee to:

iii. delegate authority to the panel to appoint the Chair, as well as the members, of the Appointments Committee

iv. delegate authority to the panel to amend the recruitment process if necessary.

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03 November 2016
Role and remit of Appointments Committee chair

The role of the Chair of the Appointments Committee has the following key elements:

- Provide guidance and assistance to the Appointments Committee, ensuring the recruitment and selection process is conducted fairly, transparently and independently;

- With other members of the Appointments Committee, and according to determined procedures; fairly, objectively and transparently:
  - agree a shortlist of potential candidates;
  - interview shortlisted candidates;
  - appoint committee members and report appointed members to the GPhC Council;

- Oversee training and development, and lead the performance management review process for both the Appointments Committee and Statutory Committee Members. This will involve:
  - overseeing and, where appropriate, taking part in, the induction and training of new statutory and appointments committee members;
  - using a coaching style to encourage self-reflection, undertaking annual appraisals of the Chairs and Deputy Chairs of the Statutory Committees; and of the Appointments Committee members;
  - following up on performance matters arising from both hearings and the Outcome Review Group meetings as and when they occur and are passed on by the Associates & Partners team
  - where necessary, taking action in accordance with the Council’s Suspension and Removal Procedure for Statutory Committee Members.

- Meet regularly with relevant senior staff to discuss any themes around committee performance that may arise; and

- Submit an annual report to the GPhC Council on the activity of the Appointments Committee – which includes providing the Council with assurance that the work of the Committee and the postholder’s work as Chair is operating well procedurally and in line with the Council’s values and policies.

The Appointments Committee Chair is appraised by the Chair of Council annually.
Appendix 2

Appointment of Members of the Appointments Committee

1.0 Introduction

1.1 The following procedure will be used for the appointment of the Chair and members of the Appointments Committee.

2.0 Purpose of procedure

2.1 This procedure has been designed to ensure that a consistent approach is used when appointing the Chair and members of the Appointments Committee.

3.0 Procedure statement

3.1 Introduction

3.1.1 The Appointments Committee has five members comprising:

- 1 Lay Chair
- 1 Lay Deputy Chair
- 3 Registrant Members (at least one of whom must be a pharmacy technician)

3.1.2 Each committee member is appointed for up to four years and may serve a maximum of two terms.

3.2 Procedure for appointing members of the Appointments Committee

3.2.1 General principles

3.2.2 Appointments must be made in a way which upholds the Nolan principles of public life and adheres to good practice in relation to equality and diversity.

3.3 The appointments process

3.3.1 A GPhC staff member will monitor membership of the committee for forthcoming vacancies. A role description and person specification will be developed internally for every new appointment for agreement by the appointments panel. The person specification will set out the experience, personal qualities, professional qualifications (if appropriate) and competencies (including exclusion criteria) against which applications will be assessed.

3.3.2 The selection criteria must not discriminate unlawfully against any group or groups in society.

3.3.3 All appointments must be marketed and/or advertised in an appropriate and proportionate way and will always, as a minimum, be advertised on the GPhC website. Marketing and any advertising used must seek to encourage a diverse range of candidates.

3.3.4 Information packs will either be made available for download from the website and/or from an assigned GPhC staff contact as advertised on the website.
3.3.5. Applicants will be required to provide information on any potential conflicts of interest.

3.3.6. Applications will be accepted in the manner and time agreed by the appointments panel, which may include the use of an application form and tests.

3.3.7. Applicants will be requested to submit a diversity monitoring form with their application.

3.3.8. During the appointments process, it may be necessary to sift applications. All sifting processes must:

- be approved by the appointments panel
- be based on the person specification and
- ensure selection is based on merit.

3.3.9. Records must be kept of the processes used to sift applications.

3.3.10. A shortlist may be constructed following the sift and candidates may be set tests to determine whether they will be interviewed.

3.4 **The selection process**

3.4.1. The panel to appoint the Chair of the Appointments Committee will comprise the GPhC Chair, one lay Council member, one registrant Council member and an independent assessor. The panel will be chaired by the GPhC Chair.

3.4.2. The panel to appoint members of the Appointments Committee will comprise the Appointments Committee Chair, one lay Council member and one registrant Council member. The panel will be chaired by the Appointments Committee Chair.

3.4.3. Panels will have access to Human Resources advice and input as required.

3.4.4. If a member of the panel knows a candidate, then he or she must declare the nature and extent of the relationship. The decision of the panel chair will be final on the question of what further action, if any, is needed to manage prior knowledge and conflicts of interest appropriately.

3.4.5. To promote consistency, interview questions will be based on the competencies outlined in the person specification.

3.4.6. GPhC staff will provide an evaluation form for use by the panel. The panel will make a note of the key interview performance points that influenced them. The panel chair or assigned member of GPhC staff will keep a clear and objective record of the panel’s rating of each candidate and agreed decision.

3.4.7. Selection of the most suitable candidate for the appointment will only be made on merit on the basis of information provided by them in their application forms, references, any tests, and their performance at interview.

3.4.8. When selecting the Chair of the Appointments Committee the panel will propose a candidate to the Council. The Council will appoint the Chair of the Appointments Committee.
3.4.9. When selecting members of the Appointments Committee the Council delegates authority to the panel to select and appoint candidates.

3.5  
Post-selection procedure

3.5.1. When a decision on appointment has been made, all candidates will be notified in writing with the minimum of delay.

3.5.2. Under the Data Protection Act 1998, candidates may request feedback on interview performance or an account of the process undertaken. Such requests will be dealt with promptly by a member of GPhC staff, using the appointment panel’s agreed records of sift and interview outcomes.

3.5.3. Appointment will be offered subject to the provision of satisfactory references which can be taken up prior to interview should the panel consider it necessary. No references will be taken up without the candidate being informed.

3.5.4. All paperwork (including applications, scoring sheets and hand written notes) should be kept and filed securely for 4 months after which they should be destroyed securely.

4.0  
Application of procedure

4.1  
This procedure applies to the Appointments Committee.
Chief Executive and Registrar’s report

Purpose
To keep Council abreast of significant recent developments.

Recommendations
The Council is asked to note this paper

1. Community pharmacy 2016/17 and beyond

1.1 The government has announced its final package of reforms to community pharmacy which includes changes community pharmacy contractual framework for England. The key changes outlined are:

Two-year funding settlement:

- Contractors providing NHS pharmaceutical services under the community pharmacy framework will receive £2.687 billion in 2016-17 and £2.592 billion in 2017-18. This represents a reduction of 4% in 2016-17 and a further reduction of 3.4% in 2017-18.
- Separately commissioned services contracted by CCGs or local authorities will not be affected.

Changes to fees and services:

- Consolidation of a range of fees into a single activity fee which would consolidate a number of dispensing-related fees into one simplified payment
- Phasing out of establishment payments.
- Introduction of a Pharmacy Access Scheme to protect access to pharmacies where the need is greatest including, but not limited to, those which are located more than a mile from the next nearest pharmacy.
- Introduction of a quality payments scheme for pharmacies that meet specific criteria including providing specific, advanced services, among other criteria.
1.2 Additionally, a £42 million pharmacy integration fund was announced to support the embedding of clinical pharmacy practice in a wider range of primary care settings.

2. **PSA publishes ‘Regulation rethought’**
2.1 The PSA has published a discussion paper *Regulation rethought* which sets out proposals for a transformation of the regulation of health and care professionals, suggesting how the ideas in its earlier paper *Rethinking regulation* could put into practice.

2.2 Alongside this, the PSA has published *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*. The paper describes a methodology for assessing the risk of harm presented by different health and care occupations. It is intended to assist government in making decisions on whether new roles should be regulated or what alternative action should be taken.

3. **Striking the balance**
3.1 The Committee on Standards in Public Life has published its report *striking the balance* reviewing the extent to which regulators uphold the seven principles of public life.

3.2 The review constitutes a ‘health-check’ of the way in which regulators manage ethical issues in their own organisations and the extent to which the unique characteristics of regulators create or demand any specifically tailored ethical solutions. The GPhC contributed to the review.

3.3 We are considering the report to see what learning we can take from it and will share this with Council.

4. **GPhC events**
4.1 We recently held two events, reports from both of which will be in the next engagement and communications report to Council in December.

4.2 On 10 October we held a seminar looking at issues relating to ethnicity and academic performance within pharmacy education and training, and on 18 October our seminar ‘professionalism under pressure’ brought together a wide range of stakeholders to build a greater understanding of issues relating to workplace pressures within pharmacy and in other parts of healthcare.

5. **CQC ‘State of Care’ report**
5.1 The CQC has published its annual overview of health and adult social care in England. *State of Care* looks at trends, highlights examples of good and outstanding care, and identifies factors that maintain high-quality care.
5.2 The report provides an overview of the CQC’s inspection findings for 2015/16 and concludes that although many health and care services in England are providing good quality care despite a challenging environment, substantial variation remains.

Recommendations

The Council is asked to note this paper.

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21 October 2016
Public business

Performance monitoring report to end September 2016

Purpose
To report to Council on operational and financial performance to the end of September 2016.

Recommendations
Council is asked to note and comment on the performance information provided at Appendix 1.

1. Introduction
1.1 This paper reports on operational and financial performance to the end of September 2016.
1.2 The sections below provide an executive summary of key areas to note within the report.

2. Fitness to Practise (FtP)
2.1 Performance improved in three standards and declined in two, although the total number of Stream 2 investigations closed or referred to the IC increased.
2.2 The number of concerns received rose by 11% although total caseload increased marginally by 0.02%. 450 cases were closed.
2.3 The age profile of the open caseload remains relatively stable, with a decrease in cases aged between 6 and 12 months. Despite the 11% increase in the number of concerns received, the number of cases below 12 months has remained consistent.

3. Inspections
3.1 Although the number of routine inspections fell below 900 in this period, the number of visits in July was the third highest recorded since the implementation of the new approach. The slight fall in this quarter does not
represent a significant change to the more sustainable and consistent performance now in place.

4. The number of pharmacies not inspected for more than 36 months and 48 months has increased, although those at the furthest end of the spectrum have been cleared.

5. **Human Resources**

5.1 Permanent staff turnover has increased, although the stability rate has improved, reflecting an increase in the number of staff with over one year’s service.

5.2 Although reported sickness figures are slightly higher than the national mean, HR is in the process of improving its information system to ensure consistent recording of absences.

6. **Finance**

6.1 The result for the year to date is a surplus of £0.5m compared to the forecast of £0.2m.

7. **Equality and diversity implications**

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

8. **Communications**

8.1 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.

9. **Resource implications**

9.1 Resource implications are addressed within the report.

10. **Risk implications**

10.1 Failure to maintain an accurate register and/or carry out our other regulatory functions efficiently and effectively could have implications on patient safety, and a significant impact on the GPhC’s reputation.
10.2 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.

11. Monitoring and review

11.1 Council will receive a performance monitoring report on a quarterly basis, providing an update of the delivery of the GPhC’s regulatory functions and finances.

Recommendation

Council is asked to note and comment on the performance information provide at Appendix 1.

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General Pharmaceutical Council
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020 3713 7811

26 October 2016
Appendix 1

Performance monitoring report: end September 2016
1. Customer services

1.1 Registrations

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>2,280</td>
<td>852</td>
</tr>
<tr>
<td>Pharmacy technicians</td>
<td>392</td>
<td>394</td>
</tr>
<tr>
<td>Registered pharmacies</td>
<td>104</td>
<td>176</td>
</tr>
</tbody>
</table>

1.2 Registration totals

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Budgeted</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacists</td>
<td>54,418</td>
<td>53,172</td>
<td>1,246</td>
</tr>
<tr>
<td>Pharmacy technicians</td>
<td>23,382</td>
<td>23,254</td>
<td>128</td>
</tr>
<tr>
<td>Registered pharmacies</td>
<td>14,428</td>
<td>14,412</td>
<td>16</td>
</tr>
</tbody>
</table>

Register totals as at 22:00:00 30 September, 2016

1.3 Median application processing times for pharmacists

<table>
<thead>
<tr>
<th>Median application processing times for pharmacists (working days)</th>
<th>Median application processing times for pharmacy technicians (working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application receipt to approval</td>
<td>Application receipt to approval</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Application receipt to entry</td>
<td>Application receipt to entry</td>
</tr>
<tr>
<td>17</td>
<td>8</td>
</tr>
</tbody>
</table>

Medians calculated for applications during the period 1 July 2016 to 30 September 2016
1.4 Contact centre

<table>
<thead>
<tr>
<th>Phone</th>
<th>2015/16 Q2</th>
<th>2015/16 Q3</th>
<th>2015/16 Q4</th>
<th>2016/17 Q1</th>
<th>2016/17 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls made to GPhC</td>
<td>21,961</td>
<td>14,096</td>
<td>9,210</td>
<td>14,017</td>
<td>18,539</td>
</tr>
<tr>
<td>Calls answered within 20 seconds (KPI &gt; 80%)</td>
<td>75.10%</td>
<td>83.8%</td>
<td>91.6%</td>
<td>81.1%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Calls abandoned (KPI &lt; 5%)</td>
<td>3.30%</td>
<td>2.10%</td>
<td>1.8%</td>
<td>2.3%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

**Correspondence**

| Email actioned within 2 days (KPI > 90%)           | 97.30%     | 97.7%      | 100.0%     | 100.0%     | 92.6%      |

The Contact Centre has, in the last quarter, been severely affected by a high turnover of staff over the summer period. This has resulted in a virtually new team and as a result, this lack of experience has been reflected in the turnover of calls and completion of email responses, during one of our busy peak cycles.
## 1.5 Continuing professional development (CPD)

<table>
<thead>
<tr>
<th>Call and submission data</th>
<th>2014-15 Call</th>
<th>2016 Call (2.5% sample pilot)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records requested</td>
<td>19,197</td>
<td>1,798</td>
</tr>
<tr>
<td>Submitted by deadline</td>
<td>17,802 (92.7%)</td>
<td>1,687 (93.8%)</td>
</tr>
</tbody>
</table>

### Submission issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>2014-15</th>
<th>2016 sample pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grantsed</td>
<td>450 (2.3%)</td>
<td>56 (3.1%)</td>
</tr>
<tr>
<td>Incomplete</td>
<td>1,400 (7.3%)</td>
<td>143 (7.9%)</td>
</tr>
<tr>
<td>Problems</td>
<td>17 (0.1%)</td>
<td>0 (0.0%)</td>
</tr>
</tbody>
</table>

### Non-compliance action

<table>
<thead>
<tr>
<th>Action</th>
<th>2014-15</th>
<th>2016 sample pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reminders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st reminder</td>
<td>1,160 (6.0%)</td>
<td>1,454 (80.9%)</td>
</tr>
<tr>
<td>2nd reminder</td>
<td>687 (3.5%)</td>
<td>111 (6.2%)</td>
</tr>
<tr>
<td>Remediation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entered into remediation</td>
<td>137 (0.7%)</td>
<td>249 (13.8%)</td>
</tr>
<tr>
<td>Removal process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notice of intention to remove</td>
<td>407 (2.1%)</td>
<td>107 (5.6%)</td>
</tr>
<tr>
<td>Notice of removal</td>
<td>213 (1.1%)</td>
<td>47 (2.6%)</td>
</tr>
</tbody>
</table>

### Overall compliance

<table>
<thead>
<tr>
<th>Compliance</th>
<th>2014-15</th>
<th>2016 sample pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met requirements at 1&lt;sup&gt;st&lt;/sup&gt; attempt</td>
<td>19,027 (99.9%)</td>
<td>1,440 (80.1%)</td>
</tr>
<tr>
<td>Met requirements at 2&lt;sup&gt;nd&lt;/sup&gt; attempt</td>
<td>19,027 (99.9%)</td>
<td>1,440 (80.1%)</td>
</tr>
<tr>
<td>Removal for non-compliance</td>
<td>170 (0.9%)</td>
<td>24 (1.3%)</td>
</tr>
<tr>
<td>Removal from call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary removal from register</td>
<td>0 (0.0%)</td>
<td>22 (1.2%)</td>
</tr>
<tr>
<td>Deleted from register</td>
<td></td>
<td>1 (0.05%)</td>
</tr>
<tr>
<td>Failed to renew registration</td>
<td></td>
<td>4 (0.2%)</td>
</tr>
<tr>
<td>CFtP pilot participation</td>
<td></td>
<td>6 (0.3%)</td>
</tr>
<tr>
<td>Pending</td>
<td>0 (0.0%)</td>
<td>82 (4.6%)</td>
</tr>
<tr>
<td>Overall compliance rating</td>
<td>19,027 (99.9%)</td>
<td>1,659 (92.3%)</td>
</tr>
</tbody>
</table>
About the data

Figures are presented as annual call cycles. 2014-15 calls commenced in October 2014 and ended in June 2015. The 2016 call is a pilot study for a sampling approach of 2.5% of the professional registers and commenced in March 2016. The 2016 call is ongoing and is not yet representative of the final degree of compliance with CPD requirements.

Data was extracted on 17th of October 2016.

Commentary

1. Incomplete refers to having approval to submit fewer entries than usually required (9 per year) as a result of periods away from practice, such as parental or sick leave.

2. Problem submissions are those that are submitted in formats that cannot be accepted and therefore it is not possible to process them.

3. In 2016, the timing of the first reminder was changed to precede the deadline for submission of records, increasing the number of reminders issued significantly.

4. There has been an increase in the proportion of registrants entering into remediation in 2016 for two reasons. Firstly, the requirements to submit the correct number of pro-rata entries of 9 per year have been tightened meaning that more registrants have been asked to submit additional entries. Secondly, the 2.5% random sample was supplemented by purposive sampling of two groups. These two groups were all eligible registrants who had previously had a period of remediation in the last five years and all registrants restored to the register that had not yet had their CPD entries reviewed. Of the registrants previously in remediation, more than 40% have been subject to remedial measures again in this call. This a significantly higher proportion than for the randomly selected registrants (c.8%) and the registrants who had been restored to the register (c.15%)

5. As with periods of remediation, there has been an increase in the instances of sending notices of intent to remove registration as a result of the purposive sampling. 9.0% of registrants previously in remediation received notices of intent to remove compared to 3.1% for the randomly selected registrants and 4.8% of the registrants restored to the register.
6 Similarly, notices of removal also increased. 3.9% and 3.8% of registrants sampled for previous remediation and for restoration to the register, respectively, received notices of removal compared to 1.3% of the randomly selected registrants.

7 Voluntary removals from the register occurred both prior to the CPD call and following it. We will be working to understand if the call was the motivation to voluntarily remove from the register in these cases. The same is also true for registrants who failed to renew registration once called to submit CPD.

8 Deletions from the register occur in cases of death or incorrect entry of a registrant. This instance was a death of registrant.

9 Pending submissions are: yet to be submitted, yet to be reviewed, in remediation periods, in removal process periods.
2. **Fitness to Practise (FtP)**

2.1 **Fitness to Practise performance standards**

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>All cases triaged during this period</td>
<td>433</td>
</tr>
<tr>
<td>Of which cases triaged within 3 working days</td>
<td>313</td>
</tr>
<tr>
<td>%</td>
<td>72.4%</td>
</tr>
</tbody>
</table>

*Cases triaged 1 July 2016 to 30 September 2016*

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>All stream 1 cases closed pre-IC</td>
<td>168</td>
</tr>
<tr>
<td>Of which closed within 3 months</td>
<td>128</td>
</tr>
<tr>
<td>%</td>
<td>76.2%</td>
</tr>
<tr>
<td>All stream 2 cases closed pre-IC or referred to the IC</td>
<td>167</td>
</tr>
<tr>
<td>Of which closed or referred within 10 months</td>
<td>134</td>
</tr>
<tr>
<td>%</td>
<td>80.2%</td>
</tr>
<tr>
<td>All cases closed or referred at IC</td>
<td>47</td>
</tr>
<tr>
<td>Of which reach IC within 12 months</td>
<td>21</td>
</tr>
<tr>
<td>%</td>
<td>44.6%</td>
</tr>
<tr>
<td>All FTP committee cases closed</td>
<td>20</td>
</tr>
<tr>
<td>Of which closed within 24 months</td>
<td>15</td>
</tr>
<tr>
<td>%</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

*Cases closed 1 July 2016 to 30 September 2016, which may have been opened at any time.*
Compared with the previous quarter, performance improved in three standards (the number and percentage of cases triaged within 3 days; the number and percentage of Stream 1 cases closed within 3 months; and the number and percentage of cases closed or referred at the IC within 12 months).

Compared with the previous quarter, performance declined in two standards (the number of cases closed by the FTPC and percentage of Stream 2 cases which were closed pre-IC or referred to the IC within 10 months) although, it is noteworthy that the total number of Stream 2 investigations which were closed or referred to the IC across the quarter increased from 167 to 186.
2.2 Cases received and closed

Across the quarter, we received an increase in the number of concerns, rising from 425 in Quarter 1, to 472 in Quarter 2 - this equates to a monthly average of 157 concerns being received compared with 142 in the previous quarter. Across the quarter we closed 450 cases. Despite receiving an 11% increase in the number of concerns across this quarter, at 30 September 2016 our total caseload increased marginally by 13 cases to 659, representing a 0.02% increase.
### 2.3 Caseload age profile

<table>
<thead>
<tr>
<th>Age profile</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sep</td>
<td>Nov</td>
</tr>
<tr>
<td>Under 6 months</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>456</td>
<td>60%</td>
</tr>
<tr>
<td>6-12 months</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>168</td>
<td>22%</td>
</tr>
<tr>
<td>12-14 months</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>2%</td>
</tr>
<tr>
<td>15 months old and over</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>121</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>765</td>
<td>100%</td>
</tr>
</tbody>
</table>

The age profile of our open caseload continues to remain relatively stable, with decreases in the number of cases aged between 6 and 12 months. Despite an 11% increase in the number of concerns being received across this quarter, the number of cases in the caseload below 12 months has remained consistent. This reflects our plan to manage newer cases at the front end of the process efficiently, whilst progressing older cases through the various fitness to practise processes to closure.

The proportion of our caseload over 12 months remains relatively stable overall, although the actual number of cases within this age cohort increased by 14 cases. This does not represent a significant increase and, largely, corresponds with the increased number of concerns received from July to October 2015 which are progressing through to closure. At 30 September 2016 our caseload, at 659, compares with 765 as at 30 September 2015.

In relation to the 155 open cases over the age of 12 months, 20 are subject to an interim order. 92 (59%) of these cases are beyond the investigatory stage. Of those cases,

- 33 are listed for hearing with the FtPC before the end of January 2017
- 19 are listed before IC meetings in October and November
35 have been referred to the FtPC and are currently being served or canvassed for hearing dates

5 cases are anticipated for closure in October

The remaining 63 cases over the age of 12 months are at the investigation stage. 19 of these cases are subject to third party intervention and therefore no further investigation can be undertaken until other agencies have completed their enquiries. Of the remaining 44 cases currently at this stage, 41 are anticipated to have concluded the investigation stage by the end of November 2016.

For the remaining 3 cases we require Court Orders for the disclosure of information, and these are being sought actively. Cases over 15 months

<table>
<thead>
<tr>
<th>Age profile</th>
<th>November</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>November</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>15-19 months</td>
<td>No</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>35.70%</td>
<td>33.00%</td>
</tr>
<tr>
<td>20-24 months</td>
<td>No</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>22.30%</td>
<td>22.30%</td>
</tr>
<tr>
<td>25-29 months</td>
<td>No</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>13.40%</td>
<td>21.30%</td>
</tr>
<tr>
<td>30-34 months</td>
<td>No</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>16.10%</td>
<td>10.60%</td>
</tr>
<tr>
<td>35-39 months</td>
<td>No</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>4.50%</td>
<td>5.30%</td>
</tr>
<tr>
<td>40-42 months</td>
<td>No</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>6.30%</td>
<td>2.10%</td>
</tr>
<tr>
<td>43-49 months</td>
<td>No</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.90%</td>
<td>4.30%</td>
</tr>
<tr>
<td>50 months or more</td>
<td>No</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.90%</td>
<td>1.10%</td>
</tr>
</tbody>
</table>
Despite the increased number of concerns being received, the direction of travel, in line with our plan to progress the oldest cases through to closure, is being sustained. Despite the increased number of concerns, the cohort of cases over 15 months remained stable, when compared with the previous quarter. Of the 108 cases within this age cohort, 16 are subject to an interim order. 73 (68%) of these cases are beyond the investigatory stage and on their way to closure. 10 of these cases are listed to be considered by the IC in October and November 2016. 31 of these cases are listed before the FtPC for hearing and 30 have been referred to the FtPC and are currently in the process of being served or canvassed for hearing dates before the end of February 2017. 2 cases are anticipated for closure in October. Of the 35 remaining cases within this age profile, 11 are subject to third party intervention and we are unable to progress the investigation until other agencies have completed their enquiries. 24 cases are within the investigation process and anticipate these investigations to be concluded before the end of November 2016.

Of the 9 cases over 40 months old, 4 are listed for hearing before FtPC and 1 is currently awaiting listed before the FtPC. 1 case is anticipated for closure in November 2016. 2 cases are subject to third party intervention. The final case in this age category requires a Court Order for the disclosure of information, and this is actively being sought.
2.4 Cases closed by stage

The average number of cases closed at IC continues to remain stable. Whilst the number of Stream 1 and 2 cases closed during this quarter reduced, it is noteworthy that the number of investigations concluded and referred to the IC increased from 38 in Quarter 1, to 58 in Quarter 2 - a 53% increase in the number of cases referred to the IC. There was also increased performance in the number of cases referred, directly, to the FtPC, increasing from 29 in Quarter 1 to 51 in Quarter 2 - a 75% increase.
2.5 DBS referrals

The Disclosure and Barring Service (DBS) and Disclosure Scotland (DS) Referrals Panel considered 16 matters during this quarter. Six matters were referred to the DBS; no matters were referred to the DS.

2.6 Appeals

At the end of this quarter there were 3 ongoing appeals. During this period we successfully concluded 4 appeals, and received no new appeals.
2.7  Interim orders

Since September 2015, the GPhC has made 41 interim order applications, of which 2 were declined. Interim orders are sought in circumstances where an order is necessary to protect the public, is in the public interest or is necessary to protect the registrant. Across the quarter, the number of interim order applications increased, notably in August. When considering issues which may justify an interim order application, these represent an operational priority for the team. Despite the unusual increase in number of interim order applications which were required in August, the team was able to sustain good performance in completing those applications in an average of 2.1 weeks. This period is taken from the time we receive information justifying the need for an IO order to the date on which the FtPC makes the decision to impose an interim order.
3. Inspection

3.1 Inspections undertaken

<table>
<thead>
<tr>
<th></th>
<th>Routine inspections</th>
<th>Follow up inspections</th>
<th>Visits before registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacies</td>
<td>869</td>
<td>42</td>
<td>62</td>
</tr>
</tbody>
</table>

Figures above relate to inspection activity between 1 July 2016 and 30 September 2016.

The number of routine inspections fell below 900 in this quarter, although the number of visits in July (317) was the third highest recorded since the new approach began. The subsequent drop in August (283) and September (269) was due primarily to the long-term absences of two inspectors and a two-day training event, the latter of which reduced the number of days available for inspection activity for the whole team. The slight fall in this quarter, does not represent a significant change to the more sustainable and consistent performance now in place.

3.2 Pharmacy premises not inspected

<table>
<thead>
<tr>
<th>Months since previous inspection</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>November</td>
<td>February</td>
</tr>
<tr>
<td>36-38 months</td>
<td># 1,270</td>
<td>1,087</td>
</tr>
<tr>
<td></td>
<td>% 32.40%</td>
<td>26.00%</td>
</tr>
<tr>
<td>39-41 months</td>
<td># 1,017</td>
<td>1,218</td>
</tr>
<tr>
<td></td>
<td>% 25.80%</td>
<td>29.10%</td>
</tr>
<tr>
<td>42-47 months</td>
<td># 1,334</td>
<td>1,558</td>
</tr>
<tr>
<td></td>
<td>% 33.90%</td>
<td>37.20%</td>
</tr>
<tr>
<td>48 months or more</td>
<td># 316</td>
<td>327</td>
</tr>
<tr>
<td></td>
<td>% 8.00%</td>
<td>7.80%</td>
</tr>
<tr>
<td>Total</td>
<td># 3,937</td>
<td>4,190</td>
</tr>
<tr>
<td></td>
<td>% 100%</td>
<td>100%</td>
</tr>
<tr>
<td>Of all registered pharmacies</td>
<td># 14,410</td>
<td>14,390</td>
</tr>
<tr>
<td></td>
<td>% 27.30%</td>
<td>29.10%</td>
</tr>
</tbody>
</table>
3.3 Age profile of pharmacies not inspected for 48 months and over

<table>
<thead>
<tr>
<th>Months since previous inspection</th>
<th>East</th>
<th>North</th>
<th>South</th>
<th>West</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>48 – 50 Months</td>
<td>#</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>160</td>
<td>71.1%</td>
<td>54</td>
<td>179</td>
<td>498</td>
</tr>
<tr>
<td>%</td>
<td>71.1%</td>
<td>80.2%</td>
<td>91.5%</td>
<td>79.9%</td>
<td>77.9%</td>
</tr>
<tr>
<td>51 – 53 Months</td>
<td>#</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>60</td>
<td>26.7%</td>
<td>9.5%</td>
<td>7.1%</td>
<td>120</td>
</tr>
<tr>
<td>%</td>
<td>26.7%</td>
<td>17.6%</td>
<td>9.5%</td>
<td>7.1%</td>
<td>18.8%</td>
</tr>
<tr>
<td>54 – 59 Months</td>
<td>#</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>5</td>
<td>2.2%</td>
<td>0.0%</td>
<td>3.8%</td>
<td>21</td>
</tr>
<tr>
<td>%</td>
<td>2.2%</td>
<td>1.3%</td>
<td>0.0%</td>
<td>5.8%</td>
<td>9.3%</td>
</tr>
<tr>
<td>+60 Months</td>
<td>#</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total</td>
<td>#</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>225</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

*One pharmacy in this category has now closed and will be removed from the register shortly.

Figures correct as at 30 September 2016

The number of pharmacies not inspected for more than 36 months has risen to 5,019, an increase of 2.9% since Q1 and 35% of all registered pharmacies. The number of pharmacies not inspected for 48 months or more has risen from 577 to 638, the oldest of which have not been inspected for 56 months. We have cleared those at the extreme end of this spectrum (i.e. those which had gone 60 months without an inspection) reflecting our aim to continue bearing down on the ‘tail end’. We are continuing to develop the sophistication of our forecasting to help us manage the continued focus on reducing the number of pharmacies awaiting an inspection over the age of 54 months.
Through the use of our floating inspectors and the prioritisation of particular areas we have now cleared work in those parts of the country which had the highest concentration of pharmacies that had not been inspected for the longest period. Due to the longer-term absences of two inspectors we have to use our floating inspectors to cover these gaps meaning clearance of some of our other oldest pharmacies has slowed slightly. To increase our resilience and capacity we have recruited two additional floating inspectors who will start work in the next quarter.

### 3.4 Top 5 standards ranked as not met

<table>
<thead>
<tr>
<th>Standard no.</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3</td>
<td>Medicines and medical devices are: obtained from a reputable source; safe and fit for purpose; stored securely; safeguarded from unauthorized access; supplied to the patient safely; and disposed of safely and securely</td>
<td>38</td>
</tr>
<tr>
<td>1.1</td>
<td>The risks associated with providing pharmacy services are identified and managed</td>
<td>33</td>
</tr>
<tr>
<td>1.2</td>
<td>The safety and quality of pharmacy services are regularly reviewed and monitored</td>
<td>27</td>
</tr>
<tr>
<td>3.1</td>
<td>Premises are safe, clean, properly maintained and suitable for the pharmacy services provided</td>
<td>26</td>
</tr>
<tr>
<td>2.2</td>
<td>Staff have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training</td>
<td>21</td>
</tr>
</tbody>
</table>

### 3.5 Top 5 standards ranked as good

<table>
<thead>
<tr>
<th>Standard no.</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Staff have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training</td>
<td>231</td>
</tr>
<tr>
<td>2.4</td>
<td>There is a culture of openness, honesty and learning</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Rank</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1.2</td>
<td>The safety and quality of pharmacy services are regularly reviewed and monitored</td>
<td>194</td>
</tr>
<tr>
<td>1.1</td>
<td>The risks associated with providing pharmacy services are identified and managed</td>
<td>191</td>
</tr>
<tr>
<td>4.2</td>
<td>Pharmacy services are managed and delivered safely and effectively</td>
<td>163</td>
</tr>
</tbody>
</table>

*The above rankings relate to inspections carried out between: 1 July, 2016 – 30 September, 2016*
The top three standards not met have remained the same, although there has been a slight change in the order. In this quarter we have seen standards around cleanliness (standard 3.1) and staffing skills/qualifications (standard 2.2) replace standards around service delivery (4.2) and record-keeping (1.6). We have not targeted any difference cohorts of pharmacies in this quarter to explain the change but it is worth noting that the numerical difference is small (20 pharmacies failed standard 4.2) and 16 pharmacies failed standard 1.6. We will continue to assess this over the next quarter. The top five standards rated as ‘good’ have remained the same although there has been a slight change in the order. In addition we have begun to disseminate more information through Regulate to highlight good practice identified through inspection. To date we have focused on safeguarding children and vulnerable adults, managing risk/reviewing safety and quality (which has consistently featured in the top grouping of both ‘good’ standards and ‘standards not met’) and privacy/confidentiality. These have received some good feedback and high numbers of views online. We will therefore continue this, looking at key areas where standards have not been met and other areas where we believe good practice needs to be highlighted. The learning from inspection has also been disseminated to the Chief Pharmacists in Wales and Directors of Pharmacy in Scotland.
4. Complaints

4.1 Formal complaints and negative feedback by category

Complaints data is now grouped entirely in calendar quarters across an 18-month period. There is a clear pattern of growth in complaint volume between the first two quarters in both 2015/16 and 2016/17. In order to understand whether this is indicative of a wider pattern across the GPhC’s annual business cycle, the reporting period will grow to 21 and then 24 months, respectively, in the next two reports to Council.

While the volume of complaints doubled between Q1 and Q2 of this year, the most common causes of dissatisfaction remained consistent. GPhC renewals account for a considerable proportion of complaints, in particular the way in which payments are made and what complainants feel is the inefficiency of the overall process. Two further areas account for a significant number of complaints are: the manner in which concerns are investigated by the GPhC and the thresholds upon which its conclusions are based; and, the way in which the GPhC communicates (both verbally and in writing) with registrants and members of the public.
5. Human Resources

5.1 GPhC overview

The data below gives a breakdown of staff movement for the previous rolling 12 months, showing permanent leavers separately from staff leaving due to the ending of fixed term contracts, a turnover figure of 18.5% is based on permanent members of staff leaving, of those 13.8% left due to dismissal or poor performance.

<table>
<thead>
<tr>
<th>GPhC</th>
<th>1st October 2015 – September 30 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount</td>
<td>217</td>
</tr>
<tr>
<td>Permanent</td>
<td>195</td>
</tr>
<tr>
<td>Fixed Term Contract</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total Leavers</strong></td>
<td><strong>54</strong></td>
</tr>
<tr>
<td>Permanent leavers</td>
<td>36</td>
</tr>
<tr>
<td>Fixed Term Contract ending</td>
<td>18</td>
</tr>
<tr>
<td><strong>Turnover - Permanent</strong></td>
<td><strong>18.5%</strong></td>
</tr>
<tr>
<td>Stability – Permanent staff (Over 1 year service)</td>
<td><strong>84.6%</strong></td>
</tr>
</tbody>
</table>

Organisational Absence – Days lost due to sickness

The following tables give an analysis of the days lost due to sickness and the corresponding cost to GPhC. Absence reason reported included a range of reasons spread evenly apart from coughs/colds/viruses which accounted for the majority of days lost. 761 days in total were lost due to sickness in the last 12 months.
5.2 Breakdown by Directorate
Directorate figures are based on the actual costs of that member of staff’s salary for the day they are off sick.

**IFTP**

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Permanent staff</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Starters</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Leavers</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Sickness days</td>
<td>40.5</td>
<td>133.5</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£6,219.86</td>
<td>£21,010.36</td>
</tr>
</tbody>
</table>
### OD/EDI

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Permanent staff</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Starters</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Leavers</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Sickness days</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£629.70</td>
<td>£1,816.19</td>
</tr>
</tbody>
</table>

### Operations

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Permanent staff</td>
<td>72</td>
<td>69</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Starters</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Leavers</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Sickness days</td>
<td>52.5</td>
<td>82.5</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£6,534.80</td>
<td>£11,711.75</td>
</tr>
</tbody>
</table>
### Executive Office

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Permanent staff</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Starters</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Leavers</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sickness days</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£2,343.51</td>
<td>£357.69</td>
</tr>
</tbody>
</table>

### Strategy

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Permanent staff</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Starters</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Leavers</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Sickness days</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£2,244.74</td>
<td>£5,473.56</td>
</tr>
</tbody>
</table>
5.3 Summary

Staff took on average 3.5 sick days per year. The national mean is 2.8 sick days as reported in a national survey by XpertHR a national HR network. However, as advised last quarter we are in the process of improving our HR Information system to ensure consistent recording of absences. Going forward this figure may increase as historically there has been under reporting of absence. As a result of more accurate information we will be able to target areas and initiatives in the future.

Our permanent turnover figure is 18.5% which represents an increase from the previous quarter. As can be seen above leavers were spread fairly evenly over all Directorates. However stability rate has improved by 3.5% which shows an increase in the number of staff with over one years’ service.

The HR Department carries out exit meetings with all leavers with the aim of identifying the root causes of turnover, thus far a highest proportion of leavers have stated lack of career progression and development for moving. In response HR are working to put into place a number of strategic measures to increase our retention levels such as improvements to induction, development and succession planning. We are also concentrating on improving our methods of recruitment and selection e.g. we are combining traditional advertising with pro-active online search undertaken by our in house team.
6. Financial performance

GPhC Balance Sheet as at 30 September 2016

<table>
<thead>
<tr>
<th></th>
<th>September 2016</th>
<th>March 2016</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquisitions</td>
<td>7,654</td>
<td>7,693</td>
<td>(39)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(2,349)</td>
<td>(785)</td>
<td>(1,565)</td>
</tr>
<tr>
<td></td>
<td>5,304</td>
<td>6,908</td>
<td>(1,603)</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>175</td>
<td>413</td>
<td>(238)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>571</td>
<td>959</td>
<td>(388)</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>48</td>
<td>142</td>
<td>(95)</td>
</tr>
<tr>
<td>Escrow</td>
<td>0</td>
<td>56</td>
<td>(56)</td>
</tr>
<tr>
<td>Bank &amp; Cash</td>
<td>25,363</td>
<td>25,249</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>26,155</td>
<td>25,819</td>
<td>(665)</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>132</td>
<td>944</td>
<td>(812)</td>
</tr>
<tr>
<td>Tax due</td>
<td>358</td>
<td>277</td>
<td>82</td>
</tr>
<tr>
<td>Grant Income</td>
<td>631</td>
<td>1,043</td>
<td>(412)</td>
</tr>
<tr>
<td>Deferred Fee Income</td>
<td>12,054</td>
<td>12,638</td>
<td>(584)</td>
</tr>
<tr>
<td>Data Sub Income</td>
<td>8</td>
<td>55</td>
<td>3</td>
</tr>
<tr>
<td>Accruals</td>
<td>1,004</td>
<td>1,126</td>
<td>(122)</td>
</tr>
<tr>
<td></td>
<td>14,189</td>
<td>15,033</td>
<td>(844)</td>
</tr>
<tr>
<td><strong>Net Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11,965</td>
<td>10,786</td>
<td>1,180</td>
</tr>
<tr>
<td>Landlord Incentive</td>
<td>3,452</td>
<td>3,845</td>
<td>(392)</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>13,818</td>
<td>13,849</td>
<td>(31)</td>
</tr>
<tr>
<td><strong>Funds Employed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated B/Fwd</td>
<td>13,360</td>
<td>15,795</td>
<td>(2,435)</td>
</tr>
<tr>
<td>Surplus/(Deficit) in Year</td>
<td>453</td>
<td>(1,946)</td>
<td>2,404</td>
</tr>
<tr>
<td><strong>Total Funds</strong></td>
<td>13,818</td>
<td>13,849</td>
<td>(31)</td>
</tr>
</tbody>
</table>

**Fixed Assets**

Fixed Assets total £5.3m and relate to works carried out to Canada Square office, office equipment purchased and CRM phase 1 development.

**Current Assets**

Current Assets include accrued bank interest and the cash relates primarily to registrants renewal fees paid in advance.

**Long Term Liabilities**

Long term Liabilities include the Landlord’s contribution to the office fit out which has been offset by long term rent increases.

The balance sheet to 30 September 2016 continues to reflect a strong net position with total assets exceeding total liabilities by almost 50%.

With the building costs now finalised the Escrow was settled during the year.

The debtors figures include the cost recovery for high court appeals. We are seeing an increasing number of awarded costs making payments via very lengthy payment plans.

Current Liabilities include grant income in relation to CRM phase 1.

The deferred income relates to the fees paid in advanced for all registrant groups and we expect to see this figure rise over the coming period.
<table>
<thead>
<tr>
<th></th>
<th>Year to date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sep-16 Actual</td>
<td>Sep-16 Forecast</td>
</tr>
<tr>
<td><strong>Pharmacist Income</strong></td>
<td>7,000</td>
<td>6,902</td>
</tr>
<tr>
<td><strong>Premises Income</strong></td>
<td>1,854</td>
<td>1,828</td>
</tr>
<tr>
<td><strong>Pharmacy Technician Income</strong></td>
<td>1,437</td>
<td>1,417</td>
</tr>
<tr>
<td><strong>Pre-Registration Income</strong></td>
<td>867</td>
<td>1,006</td>
</tr>
<tr>
<td><strong>Other Fee Income</strong></td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td><strong>Grants</strong></td>
<td>104</td>
<td>102</td>
</tr>
<tr>
<td><strong>Other Income</strong></td>
<td>84</td>
<td>102</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>11,368</strong></td>
<td><strong>11,377</strong></td>
</tr>
<tr>
<td><strong>Chief Executive</strong></td>
<td>(673)</td>
<td>(681)</td>
</tr>
<tr>
<td><strong>Inspections &amp; Fitness to Practise</strong></td>
<td>(3,687)</td>
<td>(3,693)</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td>(1,237)</td>
<td>(1,331)</td>
</tr>
<tr>
<td><strong>Organisational Development &amp; EDI</strong></td>
<td>(582)</td>
<td>(567)</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td>(3,805)</td>
<td>(3,958)</td>
</tr>
<tr>
<td><strong>Total Overheads</strong></td>
<td><strong>(9,983)</strong></td>
<td><strong>(10,229)</strong></td>
</tr>
<tr>
<td><strong>Outsourced Services</strong></td>
<td>(7)</td>
<td>(8)</td>
</tr>
<tr>
<td><strong>Rent</strong></td>
<td>(616)</td>
<td>(617)</td>
</tr>
<tr>
<td><strong>Rent Contributions</strong></td>
<td>225</td>
<td>227</td>
</tr>
<tr>
<td><strong>Service Charge</strong></td>
<td>(245)</td>
<td>(241)</td>
</tr>
<tr>
<td><strong>Rates</strong></td>
<td>(264)</td>
<td>(271)</td>
</tr>
<tr>
<td><strong>Utilities</strong></td>
<td>(62)</td>
<td>(62)</td>
</tr>
<tr>
<td><strong>Buildings Insurance</strong></td>
<td>(40)</td>
<td>(40)</td>
</tr>
<tr>
<td><strong>Total Occupancy Costs</strong></td>
<td><strong>(1,010)</strong></td>
<td><strong>(1,011)</strong></td>
</tr>
<tr>
<td><strong>Total Contingency</strong></td>
<td>0</td>
<td>(6)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>(10,993)</td>
<td>(11,246)</td>
</tr>
<tr>
<td><strong>Net Operating Surplus/ (Deficit) before Interest and Tax</strong></td>
<td>374</td>
<td>131</td>
</tr>
<tr>
<td><strong>Total Interest</strong></td>
<td>107</td>
<td>109</td>
</tr>
<tr>
<td><strong>Total Tax</strong></td>
<td>(23)</td>
<td>(29)</td>
</tr>
<tr>
<td><strong>Net Operating Surplus/ (Deficit) before Interest and Tax</strong></td>
<td>458</td>
<td>211</td>
</tr>
</tbody>
</table>

Performance monitoring report: end September 2016

Page 28 of 31

16.11.C.06
Commentary

Operating surplus/(deficit) after interest and tax

The result for the year to date is a surplus of £0.5m compared to the forecast of 0.2m.

Income

Pre-Registration income was lower than forecast for the month of September with approximately 665 sitting the exam compared to a forecast number of 1,250.

The forecast predicted a high number of students to sit the exam in September as the June sitting would have been the first under the new style of exam. The high pass rate in June meant that this was not the case. This has been offset by increased pharmacist income for July and August.

Other Income is behind forecast due to legal fees awarded being reclassified as cost recovery rather than income.

Expenditure

Savings against forecast mainly relate to employee costs, partially offset by an increase in professional fees due to panel firms. This reduction in employee costs includes payroll costs, due to vacant posts and a reduction in recruitment costs and training.

The underspend in Operations also includes a reduction in IT project costs due to phasing.
Expenditure by Cost Category

Income by Registrant Type
7. **Education**

7.1 **Accreditation and recognition activity**

<table>
<thead>
<tr>
<th>Course</th>
<th>Type</th>
<th>2016/17</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>MPharm degree</td>
<td>Accreditation</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Interim visit</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Independent prescribing</td>
<td>Accreditation</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Monitoring visit</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Level 2 medicines counter assistant and</td>
<td>Accreditation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>dispensing assistant</td>
<td>Reaccreditation</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>OSPAP</td>
<td>Reaccreditation</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Accreditation events tend to be concentrated in first two academic terms (October-December and January-March). As Q2 includes the end of teaching in the third term (April-June) and examination/marking periods, accreditation events are not held then.
Minutes of the Remuneration Committee meeting held on Thursday, 29 September 2016 at 25 Canada Square, London at 10.30am

TO BE CONFIRMED 27 APRIL 2017

Minutes of the public session

Present
Liz Kay (Chair)
Sarah Brown
Rob Goward
Berwyn Owen
Janet Rubin

Apologies
Nigel Clarke
Duncan Rudkin (Chief Executive & Registrar)

In attendance
Vivienne Murch (Director of Organisational Development and Equality, Diversity & Inclusion)
Matthew Hayday (Head of Governance)
Elaine Mulingani (Associates & Partners Manager) items 8 and 15
Sue Reed (Council Secretary)

16. ATTENDANCE AND INTRODUCTORY REMARKS

16.1. Rob Goward and Janet Rubin were welcomed to their first Remuneration Committee meeting since having been appointed as independent members of the committee on 1 October 2016.

17. DECLARATIONS OF INTEREST

17.1. The following interests were declared:
- Item 5: Performance Development Review update 2015/16
  Staff present
- Item 6: 2016 pay review process
  Staff present
- **Item 8: Council remuneration review**
  Council members present

- **Item 10: Review of GPhC expenses policy**
  All present

18. **MINUTES OF LAST MEETING**

18.1. The minutes of the meeting held on 28 April 2016 were agreed as a true record subject to a minor amendment to paragraph 2.2 – to replace ‘for’ with ‘from’.

**ACTION:** SR

19. **ACTIONS AND MATTERS ARISING**

19.1. Reference paragraph 6.3(ii) *Statutory committees’ cancellation policy review*: the committee noted that all statutory committee members and committee advisers had been informed of the policy changes, and that care had been taken to explain how it would work (including provision of a ready reckoner) and reassurance given that the changes would not affect the majority of cases. To date, no negative feedback had been received and no problems had arisen whenever the new policy had been invoked.

19.2. The committee noted that all other actions and matters arising had been closed.

20. **PERFORMANCE DEVELOPMENT REVIEW UPDATE 2015/16**

20.1. Vivienne Murch (VM) introduced 16.09.Rem.01 which updated the committee on the implementation of the revised Performance Development Review (PDR) process introduced in June 2016.

20.2. In the ensuing discussion, the following points were made:

- individuals’ objectives were linked into the business planning process during the objective setting process
- the high return rate for completed PDR forms was an excellent improvement on previous years, and the team responsible were commended for their good work
- the committee requested an update on progress at its next meeting

20.3. The committee:

(i) noted the update on the implementation of changes to the Performance Development Review process

(ii) requested an update on progress be presented at its next meeting on 27 April 2017
21. **2016 PAY REVIEW PROCESS**

21.1. VM introduced **16.09.Rem.02** which provided the committee with assurance in relation to the equitable implementation of the 2016 pay review process.

21.2. **The committee noted the paper on the implementation of the June 2016 pay review process.**

22. **INFORMATION GOVERNANCE TRAINING**

22.1. Matthew Hayday (MH) introduced **16.09.Rem.03** which updated the committee on progress with information security and data protection training.

22.2. **The committee noted the paper on progress with information security and data protection training.**

23. **RENUMERATION REVIEWS: COUNCIL MEMBERS AND ASSOCIATES**

23.1. MH introduced **16.09.Rem.04** which proposed remuneration rates for the chair and members of the GPhC’s Council.

23.2. In the ensuing discussion, the following points were made:

- Council members’ remuneration had not been adjusted since 2010
- the volume of applications to join Council continued to increase and the quality remained high
- it would be helpful to see year-on-year growth of remuneration for Council members at comparator organisations, as well as data on the number of days worked, and for a paper to be submitted to the committee’s next meeting for discussion
- Council members’ remuneration should be reviewed at the committee’s 28 September 2017 meeting when consideration could also be given to introducing a longer review cycle
- the GPhC chair’s remuneration had not been adjusted since 2010. As the chair’s current term of office was due to end on 31 March 2018, it would be helpful to undertake a review of the chair’s remuneration and for a paper to be submitted to the committee’s next meeting for discussion

23.3. **The committee:**

(i) **recommended the following proposals to Council:**

- no change to the remuneration rates for the chair and members of the GPhC’s Council
- no change to the discretionary payments for the chairs of the Audit & Risk Committee and Remuneration Committee

(ii) **asked that a paper be submitted to the committee’s 27 April 2017 meeting setting out year-on-year growth for remuneration of**
Council members at comparator organisations, as well as the number of days worked (iii) asked that a paper be submitted to the committee’s 27 April 2017 meeting reviewing the remuneration of the GPhC Chair and discretionary payments for the chairs of the Audit & Risk Committee and Remuneration Committee (iv) agreed to consider introducing a longer review cycle for Council members’ remuneration at the committee’s 28 September 2017 meeting

23.4. Elaine Mulingani introduced 16.09.Rem.05 which reviewed the remuneration of the GPhC’s Associates.

23.5. The committee agreed that, with effect from 1 April 2017, the daily fee for: (i) non-legally qualified chairs of the Fitness to Practise and Registration Appeals Committees be raised to £440 (ii) Accreditation and Recognition Panel team leaders be raised to £390

24. PAY BENCHMARKING – CHIEF EXECUTIVE & REGISTRAR AND DIRECTORS

24.1. VM introduced 16.09.Rem.06 which set out the regular benchmarking exercise undertaken to inform the remuneration of the GPhC Chief Executive & Registrar (CE&R) and directors.

24.2. In the ensuing discussion, the following points were made:

- the GPhC had, for a variety of reasons, avoided introducing performance-related bonuses for the senior team, but other options could be explored
- finance sector data had been excluded from Hay London datasets as it tended to inflate the figures but other datasets were also taken into consideration
- it would be helpful to ask Hay to run a dataset that included finance data in order to assess the impact, as well as examining other consultancies’ data, and for a paper to be submitted to the committee’s next meeting for discussion

24.3. The committee: (i) noted the paper on pay benchmarking for the GPhC Chief Executive & Registrar and directors (ii) asked that data around executive pay benchmarking be researched further and a paper submitted to the committee’s 27 April 2017 meeting for discussion
25. **REVIEW OF GPhC EXPENSES POLICIES**

25.1. MH introduced **16.09.Rem.07** which reviewed the implementation of the GPhC’s expenses policies – both staff and non-staff.

25.2. The committee:

(i) noted the broadly positive feedback on the expenses policies

(ii) approved the expenses policies for a further two years with no amendments, recommending this to the Chief Executive & Registrar and Council

26. **ANY OTHER BUSINESS**

26.1. There being no further business, the public session of the meeting closed at 12:25pm.

**DATE OF NEXT MEETING**

Thursday, 27 April 2017
Minutes of the Audit and Risk Committee meeting held on
Wednesday, 26 October 2016 at 25 Canada Square, London at 2pm

TO BE CONFIRMED 25 JANUARY 2017

Minutes of the public session

Present
David Prince (Chair)
Hilary Daniels
Digby Emson
Mark Hammond

Apologies
Mohammed Hussain
Jenny Brown (Grant Thornton)
Liz Kay (Chair of the Remuneration Committee)
Ruth McGregor (Head of Finance and Procurement)

In attendance
Duncan Rudkin (Chief Executive and Registrar)
Pascal Barras (Risk and Assurance Manager)
Matthew Hayday (Head of Governance)
Sarah Hillary (Moore Stephens)
Bill Mitchell (Moore Stephens)
Vivienne Murch (Director of Organisational Development and Equality, Diversity & Inclusion) – item 7
Saleem Akuji (Financial Accountant) – item 6
Sue Reed (Council Secretary)
Helen Dalrymple (Governance Administrator)

30. ATTENDANCE AND INTRODUCTORY REMARKS
30.1. The chair welcomed members and staff to the meeting.

31. DECLARATIONS OF INTEREST
31.1. No declarations of interest were made.
32. MINUTES OF LAST MEETING

32.1. The minutes of the public session of the meeting held on 19 July 2016 were confirmed.

33. ACTIONS AND MATTERS ARISING

33.1. Reference minute 22.2 bullet point 3: options and costs for penetration testing to be added to the actions log.  
ACTION: HD/MH

33.2. The committee noted that all other actions and matters arising would either be covered under substantive agenda items or had been closed.

34. ASSURANCE MAP UPDATES

GPhC insurance cover

34.1. Matthew Hayday (MH) presented 16.10.ARC.01 which advised the committee on insurance arrangements in place.

34.2. The committee noted the report and asked that the following reviews be undertaken with an update to be given at the committee’s next meeting on 25 January 2017:

(i) arrangements with the existing insurance broker in light of the GPhC’s current procurement policy

(ii) tax implications for staff in terms of how cover for family accompanying staff on business travel might affect their tax liability

(iii) professional liability in view of the proposed changes to inspection of pharmacy premises arrangements

Summary of information governance and IT project controls

34.3. In relation to information security for social media accounts MH reported that:

• the only staff with access to the accounts were the communications team and the Director of Strategy

• the team maintained a log of passwords which was saved on the GPhC intranet in a password protected environment. The team changed the password quarterly and also if anyone left the team. The same process was applied to the individual social media account passwords

• passwords were set in line with the GPhC’s password policy

• in terms of content the procedure for managing posts was that a weekly social media schedule was developed by the team, approved by the Head of Communications each Monday
• other ad hoc tweets were cleared by the Head of Communications (e.g. GPhC statements) or the relevant manager (if factual only)
• these procedures would not prevent the social media site itself from being hacked
• the account was is monitored carefully – including out of hours. The team would report to the social media site and change passwords if odd/unexpected content appeared

34.4. MH confirmed, in relation assurance reviews, that the following topics had been discussed at the last Audit and Risk Committee meeting on 19 July 2016 and had been added to the forward planner:
• investments
• breakeven budget
• new inspection model (longer-term)
• service transformation (longer-term)

34.5. The committee noted the update.

Q2 2016/17 Internal audit performance update and Internal Audit Plan follow-up report

34.6. Pascal Barras (PB) presented 16.07.ARC.02 which provided a quarterly update on the progress of the Internal Audit Plan and the follow-up of recommendations.

34.7. One of the recommendations was to amend the internal audit plan, replacing the planned audit on Records Management with the audit requested by Council on equality and diversity. MH referred to paragraphs 2.4 (ii) and (iii) in the paper and reported that work in relation to information security was taking more time to progress than had been anticipated. Discussions were ongoing with the IT team about how they could best deliver within their resources. This delay affected progress on the records management programme as both work streams required significant input from the Governance and Assurance Manager.

34.8. The delay meant that there would be little value in undertaking an audit at this point. It was therefore recommended that the audit days were reallocated to the equality and diversity audit, which would also maintain the internal audit budget.

34.9. The committee noted the report and asked that the following be presented at the 25 January 2017 meeting:
• an update on the progress of the service transformation project – particularly in relation to assurance and the proposed governance arrangements
• the remaining internal audit reports for 2016/17

*Internal audit report: Evidence Room Processes*

34.10. Bill Mitchell (BM) presented the above referenced report.

34.11. **The committee:**

(i) noted the report

(ii) approved the amendments to the internal audit plan

(iii) asked the GPhC to review whether it was still necessary for it to store controlled drugs (held as evidence), and to give an update at the 25 January 2017 meeting

*Internal audit report: Key Financial Controls*

34.12. BM presented the above referenced report.

34.13. **The committee:**

(i) noted the report

(ii) requested that the small number of minor issues that had contributed to the report’s green/amber status be rectified in order to restore the assurance rating to green given the key importance of this area

35. **ASSURANCE REVIEW: HUMAN RESOURCES**

35.1. Vivienne Murch gave a presentation focusing on the following questions:

- how could Council be assured that the GPhC strategy could be delivered through the right numbers of people with the right skills who were productive, well-motivated, well-managed and developed to their full potential?
- where were the greatest risks and how were they being controlled and monitored within the departmental and corporate risk management processes?

35.2. **The committee noted the HR assurance review presentation which set out, in relation to the above questions, progress made to date and next steps particularly in relation to performance management, recruitment procedures, staff development and the transformation programme.**

36. **ANY OTHER BUSINESS**

36.1. Thanks and best wishes were offered to Sue Reed for whom this would be her last meeting of the committee.

36.2. There being no further business, the public session closed at 3.30pm.
DATE OF NEXT MEETING

Wednesday, 25 January 2017 at 10am