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From time to time it’s worth taking stock of how we are doing and where we are heading.

I’ve been struck by a couple of things recently. The first is the tremendous effort that has gone into reforming our fitness to practise (FtP) processes, in keeping with our commitment to fair and proportionate regulation.

Over the past year, we have reduced the average length of our FtP hearings from three days to two, and we have reduced our overall FtP caseload by almost 30 per cent.

The second is that we are starting to issue renewal notices for the second time to the first group of registrants who joined the GPhC register in October 2010. If you are in that group, a reminder that you need to renew your registration two months before your current registration expires.

We have a busy summer ahead. In June, council is considering a summary of responses to our recent consultation on modernising the regulation of registered pharmacies. We ended up hosting or attending 35 events and meetings across Great Britain. These included Local Practice Forum and Local Pharmaceutical Committee meetings, as well as workshops with patients and members of the public in London, Liverpool, Cardiff and Glasgow.

We have had a terrific response to the consultation, with 456 responses – 350 from individuals and 106 from organisations (76 of which were pharmacy organisations) - and over 4,700 unique visitors to our dedicated website.

The council has decided to consider a report on the consultation at its June meeting, and to consider approval of the new standards at its 13 September meeting.

We will ensure that we publicise their decisions widely and work closely with the pharmacy profession on next steps. We are starting to plan the next phase of our engagement activities around taking the new standards forward and developing our new inspection model. You can follow progress here in Regula-e, on our website www.pharmacyregulation.org, and on social media sites like Facebook and Twitter.

We are consulting now on proposed changes to our rules, aimed at improving the way we work. These proposals will have most impact on how we manage fitness to practise investigations and hearings and registration applications, so I would encourage you to respond so that we put the right rules in place.

Finally, we have the results of our annual analysis of the register. It provides us with some really interesting insights into who is registered to practise as a pharmacist in Great Britain and what the current and emerging trends are. You can read more on page 6.

Can I encourage you to continue to send your thoughts and ideas to us at regulate@pharmacyregulation.org

Duncan Rudkin
Chief executive and registrar
We restarted the call and review process for continuing professional development (CPD) on 27 January, and have been calling the records of 1,000 pharmacists and pharmacy technicians every two weeks.

The vast majority of registrants have been submitting their CPD records via our online recording system. Over March and April, we reviewed 2,962 sets of records.

Since January, more than 90 per cent of registrants have achieved an overall score of excellent — meaning more than 75 per cent of good practice criteria have been met. Five per cent have achieved an overall score of good.

This means that 99 per cent of registrants are achieving a score of 50 per cent or more in line with the minimum requirement set out in our CPD standards.

This year’s call and review cycle has now been completed. We aim to hold the annual call and review cycle from November to May each year.

In June, we will be issuing renewal notices for the second time to the first group of registrants who joined the GPhC register in October 2010. A reminder that registrants need to renew their registration two months before their current registration expires.

In August, we will once again start sending out renewal notices to those registrants who joined our register from the Royal Pharmaceutical Society of Great Britain’s register — and a reminder that the deadline for renewing registration for all those registrants is 31 October.

We have restored to the register 359 pharmacists and 39 pharmacy technicians who had failed to renew their registration in the main renewal round late last year. We had removed 1037 pharmacists and 158 pharmacy technicians on 1 January for failing to renew.

We continue to make a small number of removals and restorations in line with the rolling renewal cycle.

Renewal of registration
**Conscience clause**

Our council has considered the issue of standard 3.4, known as the conscience clause, and has decided that this issue doesn’t need an early review. Instead, any consideration of standard 3.4 would be part of a wider review of our standards of conduct, ethics and performance.

Standard 3.4 says that registrants must make sure that ‘if your religious or moral beliefs prevent you from providing a service, you tell the relevant people or authorities and refer patients and the public to other providers’.

In reaching this conclusion, council considered a range of evidence. We conducted an internal review of the relevant UK and European legal frameworks; considered feedback from registered pharmacists and pharmacy technicians, and patients and members of the public; looked at the operation of this standard; and reviewed the current position of other regulatory bodies, including the General Medical Council and Nursing and Midwifery Council.

Since September 2010, no cases directly relating to standard 3.4 have been considered through our formal fitness to practise procedures.

We will bring this work forward if either external legal developments or our own regulatory experiences indicate that a review is necessary.

Any changes we propose to the standards, including to 3.4, would be subject to public consultation.

**New version of confidentiality guidance**

Due to a printing error, we have had copies of our guidance on patient confidentiality reprinted at no cost to us. The new version is enclosed with this edition of Regula+e.

A printing error meant that page 6 of the original version of the guidance was incorrectly drawn from another publication (our guidance on consent). We have always had a correct version of this guidance on our website.

You can find a copy of this guidance at: www.pharmacyregulation.org/sites/default/files/Guidance%20on%20Confidentiality_April%202012.pdf

**Registrant update**

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**Controlled drug prescribing changes**

Due to a change to the misuse of drugs regulations legislation, from 23 April this year, pharmacist independent prescribers have been able to prescribe, administer and direct others to administer any controlled drug in Schedule 2, 3, 4 and 5 for any medical condition – with the exception of cocaine, dipipanone and diamorphine for the treatment of addiction.

They can prescribe, administer and direct others to administer cocaine, dipipanone and diamorphine for treating organic disease or injury.

Before this change, pharmacist independent prescribers could not prescribe any controlled drugs under their own authority. This was the case even for the medicines containing Schedule 5 controlled drugs that could be sold over the counter by any pharmacist in a registered pharmacy.

A pharmacist’s entry on the online register will now show if they are an independent prescriber. You can check the register at: www.pharmacyregulation.org/theregister/index.aspx

As with any new area of practice, if you are a pharmacist independent prescriber considering prescribing or administering controlled drugs, you should make sure that your knowledge is up to date and you are competent in this area.

You must also make sure that all your work is covered by appropriate professional indemnity insurance, as outlined in our standards of conduct, ethics and performance - www.pharmacyregulation.org/standards/conduct-ethics-and-performance

This amendment to legislation made other changes to nurse independent prescribing, supply of controlled drugs under a Patient Group Direction (PGD), and compounding of controlled drugs.

For further guidance on these changes, you should seek advice from your professional body or other pharmacy organisation.
Renewal fees reduced by ten per cent

Renewal fees for pharmacists and pharmacy technicians will fall by 10 per cent. We proposed these reductions as part of a consultation carried out this spring and our governing council agreed to the proposals at their June meeting.

This means that fees for pharmacists will be reduced by £27 (to £240) and by £12 for pharmacy technicians (to £108). These proposals were well supported and in both cases, 75 percent of consultation respondents agreed with the changes.

Other proposals which formed part of the consultation and will now be implemented include:

- the fee for pharmacy premises remaining unchanged at £221. This proposal was supported by the majority of respondents. As we are still developing our approach to regulating registered pharmacies, we are not yet in a position to establish the future cost of this work – so to re-estimate premises fees at this stage would not be sensible
- an application fee of £413 for a pharmacist and £283 for a pharmacy technician to rejoin the GPhC register, where an individual has been removed from the Royal Pharmaceutical Society of Great Britain’s register following a disciplinary committee hearing. Just under 70 per cent of consultation respondents agreed with this proposal, which reflects the additional work involved in processing these applications
- an adjustment of fees for application and restoration to the register, based on the reason for the initial removal of the entry. Again, consultation respondents were positive about these changes with just under three quarters supporting the intention to make the fees charged more reflective of the amount of work undertaken.

We would like to thank the individuals, including both pharmacists and pharmacy technicians, and the organisations who took the time to respond to our consultation.

For more information about the changes, please see the latest news section of our website. We will also publicise council’s decision in the June edition of our stakeholder bulletin, Update, and through the pharmacy press.

The new fees will apply to renewals of registrations due to expire on or after 14 October 2012.
Analysis of the register

An analysis of the 2011 register has provided us with interesting insights, highlighting the continuation of a longer term trend of more pharmacists who are female or from an ethnic minority, but a fall in the number of pharmacists who qualified overseas.

This analysis of the pharmacist part of the register is the first of a two-part analysis. The second part will look at the pharmacy technician part of the register, and will be completed in summer 2012.

The 2011 register analysis was carried out by the Centre for Pharmacy Workforce Studies at the University of Manchester’s School for Pharmacy.

Key findings include:

- the average age of pharmacists is 39.9 years. Male pharmacists are on average almost four years older than females (42.3 years versus 38.4 years). As in the previous three years, just under a third (30 per cent) of all registered pharmacists are in the 30 to 39 year age bracket
- the proportion of older pharmacists has fallen for the fourth year running while the largest single increase (of just over two per cent) is in the 20 to 29 age bracket
- female pharmacists make up 59 per cent of the register, an increase of one per cent from 2010, and a continuation of a longer term trend. Women also make up the majority (61 per cent) of pharmacists with a registered address overseas, and of pharmacists on the register who qualified overseas (62 per cent)
- male pharmacists are particularly under-represented in Scotland, where they make up only 30 per cent of pharmacist registrants
- the proportion of pharmacists who identify their ethnicity as white has dropped by five per cent since 2010, to 61 per cent
- the proportion who identify their ethnicity as non-white has been increasing year on year - pharmacists from Asian backgrounds now represent over a quarter of the register (27 per cent), with black, Chinese, and other ethnic minorities representing a further 12 per cent. The highest representation of black and minority ethnic pharmacists is in the youngest (20 to 29) age group
- one third (33 per cent) of male pharmacists identify themselves as Asian, compared to around one fifth (22 per cent) of female pharmacists. In the Asian ethnic group, 17.4 per cent of pharmacists identify themselves as Indian, 6.3 per cent as Pakistani and almost one per cent as Bangladeshi
- 12 per cent of all pharmacists on the register in 2011 qualified overseas. There has been a fall of 670 of overseas qualified pharmacists compared with 2010. Pharmacists who qualified overseas are on average three years younger than those who qualified in England, Scotland and Wales
- the number of independent prescribers on the register has risen by 33 per cent to 2,049, whereas the number of supplementary prescribers has fallen slightly for the first time, with 20 less than in 2010
- more pharmacists joined the register in 2011 than in 2010. There were 3,824 new entrants, of which 61 per cent were women. In terms of ethnicity, just under 70 per cent were from a black or minority ethnic background. Just under 12 per cent had qualified overseas, 50 per cent of these from Europe
- a total of 8,176 people left the register in 2011, representing 16 per cent of the total number of pharmacists on the register in 2010 (when both a practising and non-practising register existed). The majority of those who left lived in England but 40 per cent were living overseas. 82 per cent of those who left the register in 2011 had been registered as non-practising.
Our response to Scotland’s Wilson Review

We have highlighted the importance of avoiding duplication of regulation in our response to the Review of NHS Pharmaceutical Care of Patients in the Community in Scotland, known as the Wilson Review.

“We are working with other regulatory bodies and organisations to reduce or eliminate regulatory overlap and identify any regulatory gaps,” our response says. “We would wish to work with the Scottish Government and other relevant stakeholders to identify any regulatory overlap or gaps that may arise as a result of this review.”

We have also highlighted that if the model for delivering NHS pharmaceutical care services in Scotland changes, we would want to work with any organisations that may be responsible for regulating the other environments from which pharmaceutical care services could be provided.

We will give careful consideration to the review’s recommendations to make sure our work takes account of developments in pharmaceutical care in Scotland.

We are also supporting the Scottish Government’s annual regulatory conference, which is due to be held in Glasgow on 6 November. We are contributing to planning the event and will have a team of GPhC staff available at the event should delegates have issues they wish to discuss with us.

National Assembly for Wales Inquiry into community pharmacy

The Health and Social Services Committee has published the findings of its inquiry into current arrangements and potential future roles for community pharmacies in Wales. The committee heard from witnesses and evidence was submitted about the role that community pharmacists and pharmacies currently play, the enhanced role they might play in the future and some of the barriers to improving services.

In its findings, the committee acknowledged that there is more community pharmacy could do to contribute to health services in Wales, as it was able to reach into communities that other services could find difficult to access. This was a key strength of the community pharmacy network.

Their report suggested there were significant barriers to realising the full potential of community pharmacy and that these barriers lay both within the profession and between professional groups in the health service.

They said more work needed to be done to bring the standard of the whole pharmacy network up to the standard of the best, and that there was a need for more inter-professional responsibility to resolve some of the issues between professions which posed barriers to the future development of community pharmacy.

While we did not put a submission into the inquiry, we raised our role in pharmacy regulation with committee members and staff. And our recent work in Wales consulting on proposals for new standards for registered pharmacies highlighted the increasing variety of pharmacy services delivered across Great Britain and that these services are highly valued by the public.

One of the committee’s key recommendations was that pharmacists have access to summary patient records and that patients might in the future register with community pharmacies. The GPhC recently issued guidance on patient confidentiality to support pharmacy professionals in this area.
Inquiry into education, training and workforce planning in England

The UK Parliament’s Health Select Committee has looked at the UK Government’s plans to reform education, training and workforce planning for health professionals, including pharmacy professionals, in England.

We submitted written evidence to the committee’s inquiry and a number of the issues that we raised have been addressed in the inquiry’s recommendations.

The committee has welcomed the proposed reforms, including the creation of a national leadership body called Health Education England, which will oversee the work of local education and training boards.

Their report does, however, warn that the government needs to provide more information about how these bodies will operate and work together with other organisations. There is a specific recommendation that greater clarity is needed regarding the role of Health Education England in relation to the professional regulators, including the GPhC.

Chief executive and registrar, Duncan Rudkin, said: “The need for greater clarity about how Health Education England will work with the professional regulators was a key issue that we raised in our evidence to the committee, and it is helpful that this report has reflected our concern and made a recommendation in this way.

“Setting standards and assuring the quality of the education and training of pharmacy professionals are important parts of our statutory role. It will be essential for us to work closely with Health Education England to make sure pharmacy professionals are receiving the right training and education.”

The committee’s report, which is available at www.parliament.uk/healthcom, also highlighted other key issues we raised, including how the new system will relate to systems in the other countries of the UK.

Education and training in Northern Ireland

We have revised our Education Standards to clarify aspects of accrediting the initial training and education of pharmacists in Northern Ireland, and our recognition of people holding accredited degrees from there.

While the GPhC’s remit does not include Northern Ireland, we work in close cooperation with the Pharmaceutical Society of Northern Ireland (PSNI) to make sure there are consistent standards of education and professional practice.

The changes encourage collaborative working between the GPhC and the PSNI. A key change is the proposed merger of accreditation teams from the two regulators, reducing both the size of teams and the costs to providers seeking accreditation.

Accreditation appeals will be heard by the GPhC’s Appeals Committee.

The revisions also clarify arrangements for people holding accredited degrees from Northern Ireland. They make clear that:

• a trainee has to undertake pre-registration fully in one jurisdiction so that a complete set of performance standards are met, and has to sit a national registration assessment in the same jurisdiction as the one in which they undertook pre-registration training, and register in that jurisdiction before being eligible to register in the other jurisdiction, and

• periods of pre-registration training, as well as sitting the assessment when the Royal Pharmaceutical Society of Great Britain was the regulator, count towards the initial education and training requirement of our requirements for initial registration.
Our view on proposed changes to regulation

In the last edition of Regula+, we reported on the Law Commission’s review of the regulation of healthcare professionals, aimed at streamlining the complex legislative arrangements that sit behind the work of each of the nine regulators in this area. We have now finalised our response to the review.

The Law Commission’s consultation contained over 150 proposals. We did not attempt to address all of the questions but rather focused on the proposals of most interest to us, including those about registers and fitness to practise. Our response was agreed by our governing council on 17 May.

As our response sets out, we support the over-arching aim of the review to create a new legal framework to enable regulation to adapt and provide flexible and responsive systems that protect public safety and promote high standards in professional practice.

We agree with the Commission’s analysis that the current framework creates inconsistencies in the ability of the regulators to deliver their statutory functions. But we have also flagged that as the newest of the nine regulators, we have the most recent legislation (the Pharmacy Order 2010) which we think is working well.

We have argued against further significant and disruptive change for the pharmacy professions or which might create uncertainty for patients and the public. As the newest regulator, we think it is too early to identify specific governance issues and consider the case for further change.

We agree that healthcare professional regulators should continue to be legally responsible for upholding public trust in the professions, as well as protecting public safety.

The review has proposed a series of detailed changes and additions, and here is our response to some of those proposals.

We agree that the Government should be given regulation-making power to add, remove or alter parts of the register and specialist lists. This is in line with our view that regulators should not have the final say on the scope of their own regulatory task.

We support the need for regulators to establish an appeals process and a proposal to move away from appeals to county courts or sheriffs in Scotland. We agree that the High Court is likely to be better placed to make these decisions.

However, we see any move to introduce student registers as costly, bureaucratic and likely to add a significant regulatory burden to students and universities, as well as the regulators. Nor do we support maintaining non-practising registers.

On fitness to practise, we support a two-stage approach to determining impaired fitness to practise based on whether a registrant poses a risk to the public and whether confidence in the profession has been or will be undermined.

We agree with the Commission’s assessment that there should be harmonisation of sanctions across the regulators and would support the introduction of common terminology.

We also support further structural separation between investigation and adjudication functions but would want to see this applied consistently across all the regulatory bodies at the same time.

However, we do not support a proposal to apply a new test requiring someone to demonstrate that they are a “fit and proper person”, particularly when we have an established fitness to practise test.

Finally, we thought the suggestion that the regulators should share a duty to co operate was worthwhile, and can see significant opportunities in the areas of policy development and engagement.

For more details, our response can be found at: www.pharmacyregulation.org/our-response-law-commissions%E2%80%99-consultation
Consultation on proposals to change rules

We are seeking views on changes to some of the rules that set out how we carry out our functions as a regulator and would welcome your input.

The proposals aim to improve our rules governing statutory committees, the advisers to those committees, fitness to practise proceedings and the evidence of identity required as part of the registration process.

The proposals include:

- changing part of the requirements for identity checks for registration so it is more straightforward for applicants to provide the necessary documents, at the same time as making sure the identity documents are genuine
- increasing the maximum number of panellists on statutory committees, to make sure there are enough panellists available and hearings can take place as soon as possible
- allowing panellists to be members of both the fitness to practise committee and appeals committee, to provide greater flexibility and make sure panellists can maintain their skills. We would make sure that a panellist assigned to an appeals case was not involved in any related fitness to practise hearing, in order to avoid any conflicts of interest
- making council responsible for deciding policies regarding the criteria for referral of cases to fitness to practise committee and appropriate sanctions. The guidance documents produced by council would be used by the statutory committees when they make decisions in individual fitness to practise hearings. The investigating committee and fitness to practise committees have previously produced their own guidance

Duncan Rudkin, chief executive and registrar, said:

“We are always looking at how we can work more efficiently, while meeting the standards that the public and pharmacy professionals have a right to expect. We have used our experience so far to identify a number of amendments to our rules to improve the way we work.

“These changes will have a real impact on how we manage fitness to practise investigations and hearings and registration applications. We want to encourage as many responses as possible from pharmacy professionals, patients and the public and others with an interest in pharmacy regulation, to help us to put the right rules in place.”

The consultation runs until 12 July. Our council will consider its decision on the future of the rules at a meeting on 13 September.

You can respond to this consultation in a number of ways


If you want to print off and fill in the questionnaire, you can send your completed form to:

Email: consultations@pharmacyregulation.org

By post: Draft Amendments to Rules consultation, Consultation Response, Governance Team, General Pharmaceutical Council
129 Lambeth Road
London
SE1 7BT

Responses must be received by 12 July 2012.
Registration assessment reminder

For those sitting the registration assessment on 29 June, here is a quick reminder of some key points:

Reference sources
These two reference sources are permitted in the assessment hall for the afternoon open book paper only:
2. GPhC standards of conduct, ethics and performance (September 2010)

What you can bring into a venue
You can store most of your belongings in the cloakrooms provided. Once you enter the assessment hall, you can only bring in the following items. We have compiled this list in cooperation with the British Pharmaceutical Students’ Association (BPSA):
- water and non-fizzy drinks
- sweets, if you have a cough
- medications or other items, if you have a medical condition
As well as these, you can have on your desk:
- HB pencil (or softer shade)
- pencil sharpener
- pencil eraser
- specific reference sources – open book only
You cannot bring in anything else, and that includes sweets, fruit and fizzy drinks.

Results
An online pass-list will be available on the GPhC website on:
Friday 27 July 2012, for the June 2012 assessment
Friday 26 October, for the September 2012 assessment
Registration assessment results will not be given by telephone or email.

London Olympic Games
For anyone taking the assessment in London, please take account of the Olympic Games, particularly if you are arranging travel and/or accommodation. While the sittings are either side of the Olympic Games, you may need to book your travel earlier than originally planned or even stay overnight, and accommodation may be more heavily booked than usual.

Venues
Details of the venues are included in the Spring 2012 pre-reg bulletin, which is available to download at: www.pharmacyregulation.org/spring-2012-pre-reg-bulletin and in the last edition of Regula+e.
Dear Editor,

I write in response to the letter from Richard Lee in issue 4 of Regula+e. There are over 20,000 pharmacy technicians on the register and for many registration will be a relatively new experience. Some may be apprehensive about CPD and may be looking for support in completing the CPD requirements to remain on the register.

The role of the regulator is to ensure that CPD has been completed and this is an important part of the process for protecting patients.

The Association of Pharmacy Technicians UK (APTUK) is the professional leadership body for pharmacy technicians. APTUK has an important role in working alongside the General Pharmaceutical Council helping pharmacy technicians to achieve professional excellence.

We strive to provide appropriate CPD support to pharmacy technicians who are members of APTUK. We currently provide that support to members through a number of mechanisms including a free, one-to-one, CPD pre-review service utilising our own network of accredited CPD Facilitators. We also provide on-demand CPD support to groups of members on an ad-hoc basis.

These services are all included in our annual membership fee.

We are also currently working on the introduction of post nominals which pharmacy technicians who are members will be able to use after their name to mark them out as committed to professional excellence.

You can find out more about us at www.aptuk.org

Steve Acres
President
Association of Pharmacy Technicians (UK)
Fitness to practise update

Seven day rule on cautions and convictions

Can we remind registrants that you must notify us of any cautions or convictions within seven days of receiving them.

This is part of notifying us about any change in circumstances relating to the fitness to practise declaration made as part of your application or renewal process, and also covers health matters.

You must notify us within seven days of the change occurring. You can do this by completing a ‘something to declare’ form, which you can find at:


If we are not notified, and within the seven-day time limit, the GPhC can charge a separate allegation and a registrant could end up with a dishonesty allegation being made against them.

We have had a number of cases recently where registrants have either failed to notify us and the police have done so, or where the notification has come months or even years later. Two of these matters have recently resulted in letters of warning, which appear on the publicly-available register.

Improving fitness to practise

We have reduced our caseload (GPhC and legacy cases) by 30 per cent since becoming the pharmacy regulator. We have put a lot of time and effort into streamlining our fitness to practise processes and doing this work as proportionately as we can.

By the end of 2011/12, we had reduced the average length of fitness to practise committee hearings from three days to two.

We have also improved our database and introduced new case monitoring arrangements, and we have started trialling a new case-handling process which we plan to roll out in the summer.
Fitness to practise – determinations

If a fitness to practise committee determines that a registrant’s fitness to practise is impaired, the committee may impose a sanction that is proportionate to the conduct that has been found proven. This may include, for example, issuing a warning, placing conditions on the individual’s registration, suspension of registration or, in the most serious cases, erasing the individual from the register so that they can no longer practice.

The matters listed here include the registrant’s registration number, date of determination and the sanction.

Determinations of the facts and additional information about the hearings can be found on our website at www.pharmacyregulation.org/search/search_decisions

Smith, Matthew Jonathan, 2052446
Determination date 8 February 2012
Suspension for five months

Lal, Roshan, 2023572
Determination date 15 March 2012
Suspension for twelve months

Patel, Jyoti, 2039062
Determination date 3 April 2012
Removal from the Register

Omar, Riaz Ahamed Abdul Sattar, 2036323
Determination date 5 April 2012
Review hearing in respect of suspension previously imposed on registration.
Conditions imposed on registration for a period of two years from the date of the expiry of the suspension

Onilari, Bolade Oluwadare, 2067110
Determination date 10 April 2012
Suspension for four months

Austinskaite, Aukse, 2071786
Determination date 16 April 2012
Suspension for 12 months

Murty, David James, 2017878
Determination date 17 April 2012
Suspension for three months

Dick, John Brown Barry, 2022354
Determination date 23 April 2012
Review hearing in respect of conditions previously placed on registration. Order of conditions on his registration extended for 12 months, with a review before the end of that period

Glackin, Brendan Ambrose, 2055187
Determination date 25 April 2012
Suspension for 12 months

Willingham, Gary Peter, 5008851
Determination date 27 April 2012
Suspension for 12 months

Shaikh, Noor Mohammad Zafar, 2059250
Determination date 8 May 2012
Removal from the Register

Morrison, Stephen David, 2065277
Determination date 14 May 2012
Removal from the Register

Jones, Simon David Trevor, 2057742
Determination date 15 May 2012
Review hearing in respect of conditions previously placed on registration. Order of conditions varied and placed on his registration for 12 months, with a review before the end of that period

Anwar, Waseem, 2044931
Determination date 25 May 2012
Removal from the Register

Whyte, Ferguson, 2030786
Determination date 25 May 2012
Removal from the Register
Interim orders:

Rafiq, Haroon, 2052450
Decision date 3 April 2012
Review hearing. Conditions on registration to remain in force and to be reviewed in a further 6 months

Dondo, Francis Xaverio, 2055363
Decision date 13 April 2012
Suspension for 18 months, subject to review

Badham, Paul Steven, 2021446
Decision date 13 April 2012
Review hearing. Conditions imposed on registration, in place of the previous suspension order

Aslam, Badar Masud, 2064222
Decision date 1 May 2012
Review hearing. Conditions on registration to remain in force

Llewlyn Davies, Roger, 2011875
Decision date 4 May 2012
Review hearing. Suspension to remain in force
14 May 2012: The High Court extended the interim order for a further period of 12 months to be reviewed every three months

Mukhtar, Zafferabbas, 2051643
Decision date 8 May 2012
Conditions imposed on registration for a period of 18 months, with a review after 6 months

Kadom, Mohanad, 2060825
Decision date 8 May 2012
Suspension for 18 months, with a review after 6 months

Gokaraju, Satya Narayana Raju, 2035334
Decision date 10 May 2012
Suspension for six months, subject to review

Yousaf, Mohammad Atif, 2048146
Decision date 15 May 2012
Review hearing. Suspension to remain in force

MacGregor, Simon John, 2055084
Decision date 28 May 2012

Please check the GPhC register for warnings for individual registrants.
We receive concerns about pharmacy professionals from a wide variety of sources. Some of the concerns fall below our threshold criteria and so do not get referred on to our investigating committee or fitness to practise committee. Cases are only referred to these committees where there is reason to believe that the registrant’s fitness to practise may be impaired. We are keen to share learning from a variety of cases to improve practice and for registrants to better understand how we deal with these matters.

Deficient professional performance
For the first time, our fitness to practise committee has found that a pharmacist’s fitness to practise was impaired on the grounds of deficient professional performance, rather than misconduct.

If a pharmacist is found to have deficient professional performance, this means they have demonstrated a standard of professional performance which is unacceptably low and falls short of what is expected of a registered pharmacy professional, as demonstrated by a fair sample of their work over a period of time.

In this case, the pharmacist had qualified in Lithuania and was registered to practise in Great Britain under the provisions of European law which require the European Union (EU) member states to recognise the formal qualifications of pharmacists from other EU countries.

The pharmacist had joined a pharmacy group and started a pharmacist conversion trainee program for overseas pharmacists, but did not perform well, causing concern in a number of areas of practice.

She had made a number of dispensing errors, including dispensing ropinirol at 10 times the strength of the prescription and dispensing 112 tablets of frusemide when only 28 had been prescribed.

The pharmacist had resigned and joined another employer in Scotland. Sixteen separate dispensing errors were recorded over an eight-month period.

Three of those errors involved methadone, and she had also dispensed hydroxyzine (an anti-histamine) instead of hydralazine (a drug for reducing blood pressure). Despite efforts to improve her performance, she was not regarded as being up to the standard required.

The committee said that many of the dispensing errors were serious and that the errors had been frequent. They found that the pharmacist presented an actual risk to patients.

The committee said that there had been deficient professional performance by the pharmacist. The committee said no evidence had been presented that the pharmacist had taken steps to remedy her deficiencies, nor any reports which let them state with confidence that she could fulfil the high standards required of a pharmacist.

There was also no evidence presented that gave the committee any indication that the pharmacist understood the serious consequences of her “many deficiencies” in the course of practice.

The committee noted that the pharmacist had left her employer in 2011 expressing an intention to return to Lithuania, and was currently living in Spain.

The committee found that the pharmacist’s fitness to practise was impaired and a 12-month suspension was imposed.

The committee said that they thought the pharmacist should be “given the opportunity to come back to pharmacy and to learn to do the job properly”. It ordered a review before the expiry of the suspension.
The committee said that if no evidence was presented at the review that the pharmacist had any intention of learning to practise at an acceptable level of competence, then the review committee would “be minded to think that her name should be removed, or at least the period of suspension should be extended for another year”.

In an interview with an inspector, the pharmacist had said that on the first occasion he thought the patient must have had a prescription but that it had been lost in the pharmacy. He had not noticed the lack of a prescription until the patient had come in four days later.

The pharmacist said he had looked for the prescription but could not find it, and had assumed it had fallen down the back of a drawer. He had called the prescribing doctor to check that a prescription had been issued and this was confirmed. The doctor would not, however, issue a duplicate prescription.

The pharmacist had issued the methadone to the patient because he assumed that the pharmacy held the prescription.

The pharmacist confirmed that no entry had been made in the controlled drugs register for either of the two dates in November and that he had tried to delete the relevant PMR. He said that he had panicked, thinking he would be dismissed from his job. He was going on holiday for the next two days and thought he would be able to sort it out when he got back.

The pharmacist was also alleged to have made three dispensing errors over a five-month period. The pharmacist gave evidence to the fitness to practise committee, accepting responsibility for all these errors.

Since the dispensing errors had occurred, he said he had reviewed his practice.

The committee said that the dispensing errors clearly presented a potential risk to patients, and dispensing a controlled drug without a prescription was a potential risk to patients and the public.

They found that the pharmacist had acted dishonestly and that his conduct amounted to serious misconduct. While he had shown some insight, he had not accepted that he had acted dishonestly in seeking to cover the matters up and did not fully acknowledge the seriousness of his actions.

In deciding on the appropriate sanction, the committee took into account that there had been no financial or other personal gain to the pharmacist and that no actual harm had occurred to patients. The pharmacist had a previously unblemished career, and had altered his practice.

The committee imposed a three-month suspension.

Learning points
- the GPhC’s the fitness to practise committee can find a pharmacist’s fitness to practise impaired by reason of deficient professional performance
- you must only practise in areas where you are competent, and recognise when your knowledge or skills are not satisfactory, or up to date, and as such may present a risk to patients or the public
- you must learn from your mistakes, assessments and reviews and undertake further training where needed
- employers should be alert to deficient professional performance issues and take appropriate steps, which may include referring a pharmacy professional to the GPhC in appropriate cases

Covering up dispensing errors
The fitness to practise committee heard that a pharmacist had twice, over four days, dispensed methadone to a patient without a valid prescription in his possession.

The patient had an instalment prescription for methadone for the period in question. The pharmacist had presumed the prescription was in the pharmacy. When he had realised it was not in the pharmacy he had tried to cover this up by not entering the two supplies into the controlled drugs register and by trying to delete the relevant patient medication records (PMR).

Learning points
- you must always be open and honest in your practice
- if you make a dispensing error you should carry out a root cause analysis to identify whether there was an underlying cause for the error and review your practice accordingly. You should also make a record of the error and any action taken in your error log. More information on what to do in the event of a dispensing error can be found in our document ‘Responding to complaints and concerns’ which you can find here www.pharmacyregulation.org/sites/default/files/Responding%20to%20complaints%20and%20concerns%20g.pdf
- when supplying a schedule 2 or 3 controlled drug you must mark the prescription with the date at the time of supply, and make accurate records in the controlled drugs register of all schedule 2 controlled drugs supplied. If you unintentionally give out a medicine without a legally valid prescription, you should make a record of the incident in your error log and review your practice and the procedures in the pharmacy. You must consider contacting the doctor to inform them of the error and the controlled drugs liaison officer (CDLO)
- You must never try to cover up a dispensing error or a mistake that you have made.
Sending offensive emails

The fitness to practise committee heard that a pharmacist had used a computer to generate offensive and disruptive messages under the name of the Associate Chief Pharmacist of the hospital where he had been working as a locum.

The pharmacist had made it appear that five emails which he had generated had either come from the Associate Chief Pharmacist or been sent to that person from other staff. The committee described the content of those emails as “offensive and distasteful”.

The pharmacist had left his job at the hospital shortly after the emails had been uncovered and no further action had been taken.

Two years later, the pharmacist was working as a community pharmacist. He had gained unauthorised access to his employer’s computer from home and had placed inappropriate wording on a patient’s medication record. He had done this in a way that concealed his identity. His employer had investigated the matter and he had denied responsibility, blaming other staff.

The matter came to the attention of the previous regulator, who had on file the earlier email incidents. The police were called and after a lengthy interview, the pharmacist finally admitted responsibility for the entry on the patient’s medication record.

This is one of the legacy cases that came to the GPhC from the previous regulator. Our fitness to practise committee found that the pharmacist had failed to act with integrity and to adhere to accepted standards of professional and personal conduct. They considered that what he had done amounted to “serious misconduct”.

The generation of the emails was malicious and damaging, with the potential to cause enmity and disruption within the hospital or community pharmacy where he was working.

In considering the appropriate sanction, the committee took into account that he had not practised since 2009 and that there had been no harm to patients. However, the pharmacist had shown a significant lack of insight and a message needed to be sent to the profession and the public that his conduct was unacceptable and not befitting of a pharmacy professional.

He was suspended for five months, with a review before the expiry of the suspension in order to check that in the event that he considered returning to practice, his knowledge of pharmacy and present day pharmaceutical practice was up to date.

The importance of checking a patient’s understanding of their methotrexate dose

A case that was reviewed by our investigations and case management team has highlighted the issue of checking monitoring books and a patient’s understanding of their methotrexate dosage.

A 76-year-old man with a complicated medical history had continued to increase his dosage of methotrexate tablets without his GP, hospital staff or dispensing pharmacist knowing. After his death, the post mortem had found that methotrexate toxicity was among the causes of death.

A coroner’s inquest had concluded that protocols had not been fully implemented, allowing the patient to inadvertently exceed the recommended dosage over time, which precipitated his death.

The patient had started a course of methotrexate tablets in February 2009, prescribed by a hospital consultant. The tablets had been dispensed at a community pharmacy.

The pharmacist who dispensed the tablets had checked that the patient had a methotrexate monitoring book and said he had stressed the importance of keeping that record up to date.

In June 2009, the patient’s dosage was increased by one tablet a week to a total of 10 tablets weekly. His consultant had explained this to the patient, a prescription was issued, and this was dispensed at the same pharmacy. Each prescription was dispensed on the same day of each week, when it was due, and the pharmacist dispensed the right number of tablets.

Learning points

- you must show respect for patients, members of the public and others that you work with
- you should not make derogatory comments about patients or other members of staff
- you must take steps to make sure that any computer system used in the pharmacy is secure to prevent unauthorised access
The pharmacist said he had seen the patient’s methotrexate monitoring book on two to three occasions at the start of treatment and again around the time the dosage was increased, when he had again discussed the tablets regime with the patient. The pharmacist felt that the patient had understood what was required. He had routinely asked to see the monitoring book but the patient didn’t always have it available.

Once the 10 tablets a week dosage had been reached, the prescription was for 40 tablets, labelled as ‘take 10 each week’, and they were dispensed at four-weekly intervals from the pharmacy. There was no reason for the pharmacist to think that the patient might be taking more than was stated on the prescription.

In October, the patient’s wife had taken a prescription for methotrexate and codeine phosphate (for diarrhoea) to the pharmacy. She had questioned the quantity of tablets saying he needed 17 tablets for the following week. The pharmacist said alarm bells had started ringing and he had said that the patient should stop taking the tablets immediately.

The patient died the following week.

Our investigations and case management team concluded that the pharmacist had no reason to believe that the patient was taking the methotrexate tablets in a way other than that prescribed, and had monitored the quantity of tablets supplied to the patient.

The pharmacist had followed guidelines which set out the need to ask for the methotrexate monitoring book, and as he had no reason to think the dosage was not being followed, he did not insist on seeing it on every occasion.

The pharmacist had identified there was a problem with the dosage that the patient was taking and acted immediately to resolve the issue. The case was closed with no further action being taken.

The pharmacist told her not to let the patient take any more methotrexate tablets until he had spoken to the patient’s GP. The GP agreed that the patient should stop taking the tablets immediately.

Learning points

• you must always make sure patients know how to use their medicines. You should take time to counsel patients, or their carers, on their methotrexate dose and signs of toxicity, and confirm their understanding

• be aware of other medicines which also require monitoring - you should do all you can to increase compliance with these medicines

• your local primary care organisation may also have produced guidance for dispensing these types of medicines which should be followed

• The National Patient Safety Agency (NPA) has produced a number of documents for improving compliance with oral methotrexate which are available on their website (www.nrls.npsa.nhs.uk/home/)
Check that a pharmacy professional is registered:
www.pharmacyregulation.org/theregister/index.aspx

Copies of Regula+e are available to download from our website www.pharmacyregulation.org/publications

We welcome feedback and comments on this publication which can be sent to regulate@pharmacyregulation.org