Council meeting
12 July 2018
13:30 to 16:00 approx.
Council Room 1, 25 Canada Square, London E14 5LQ

Public business

1. Attendance and introductory remarks
   Nigel Clarke

2. Declarations of interest
   Public items
   All

3. Minutes of last meeting
   Public session on 07 June 2018
   Nigel Clarke

4. Workshop summary – 7 June 2018
   Nigel Clarke

5. Actions and matters arising
   Nigel Clarke

   For noting
   Laura McClintock

7. Strategic approach to engagement with patients and the public and their elected representatives
   For noting
   Rachael Oliver

8. Rebalancing Medicines Legislation & Pharmacy Regulation: Consultation
   For noting
   Priya Warner

9. Learning from the Registration Assessment 2010-2018
   For discussion
   Mark Voce

10. Monitoring and governance of revalidation for pharmacy professionals
    For noting
    Osama Ammar

11. Gender pay gap reporting 2017
    For noting
    Francesca Okosi

12. Council member appointments 2019
    For approval
    Laura McClintock
13. Any other public business  

Nigel Clarke
### Confidential business

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<tr>
<td><strong>14.</strong> Declarations of interest</td>
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<td>Confidential items</td>
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<td><strong>15.</strong> Minutes of the last meeting</td>
<td>Nigel Clarke</td>
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<td>Confidential session on 7 June 2018</td>
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<td><strong>16.</strong> Confidential actions and matters arising</td>
<td>Nigel Clarke</td>
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<td><strong>17.</strong> Any other confidential business</td>
<td>Nigel Clarke</td>
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#### Date of next meeting

Thursday, 13 September 2018
Minutes of the Council meeting held on Thursday 7 June 2018 at 25 Canada Square, London at 13:30

TO BE CONFIRMED 12 JULY 2018

Minutes of the public session

Present
Nigel Clarke (Chair)  Elizabeth Mailey
Mary Elford  Arun Midha
Digby Emson  Berwyn Owen
Mark Hammond  David Prince
Mohammed Hussain  Samantha Quaye
Alan Kershaw  Jayne Salt

Apologies
Jo Kember
Evelyn McPhail
Megan Forbes
Matthew Hayday

In attendance
Duncan Rudkin (Chief Executive and Registrar)
Claire Bryce-Smith (Director of Insight, Intelligence and Inspection)
Francesca Okosi (Director of People)
Mark Voce (Interim Director of Education and Standards)
Laura McClintock (Chief of Staff)
Tarun Chotai (Interim Head of Finance and Procurement)
Alicia Marsh (Head of Professionals Regulation)
Julian Graville (Interim Head of Inspection)
Rachael Oliver (Head of Communications)
18. Attendance and introductory remarks
  18.1. The Chair welcomed all present to the meeting. Apologies had been received from Jo Kember, Evelyn McPhail, Megan Forbes and Matthew Hayday.

19. Declarations of interest
  19.1. Council agreed that members would make any declarations of interest before each item.

20. Minutes of the last meeting
  20.1. The minutes of the public session held on the 10 May 2018 were confirmed as a fair and accurate record.

21. Workshop summary – 10 May 2018
  21.1. Council noted the discussions from the workshop.

22. Actions and matters arising
  22.1. Action ref. 59.9; Mark Voce (MV) told members that this would be coming to the next meeting in July and apologised for the delay.
  22.2. Action ref. 12.1; the amended minutes were circulated to members. A minor amendment has been made to better reflect a Council member’s comments about the feedback from one of the focus groups on the registered pharmacies consultation. Members approved the changes.
  22.3. Action ref. 17.1; Claire Bryce-Smith (CBS) explained that where vending machines had been used to dispense prescriptions, that part of the premises had been de-registered so that it was lawful. This was because in registered premises the responsible pharmacist must be present in order to dispense. A note explaining this in more detail could be circulated to members after the meeting.
23. Annual Report, FtP report and accounts

23.1. Duncan Rudkin (DR) presented 18.06.C.01 to Council for them to approve the statutory annual report and accounts for 2017/18.

23.2. The letter of representation had been updated with a point about dilapidation provisions and was tabled at the meeting.

23.3. One member highlighted the section on fraud and error in the external auditors’ report and asked when the organisation’s fraud /anti-bribery policy was due for review. The chair of the Audit and Risk Committee (ARC) replied that it would be coming to their next meeting in July.

23.4. Council:

i. Approved the combined annual report, annual accounts and fitness to practise report for 2017/18

ii. Authorised the Chair of Council to sign the letter of representation as required by the auditors

24. Budget reforecast

24.1. DR presented 18.06.C.02, which sought the approval of Council for the revised budget for the 2018/19 financial year.

24.2. The context of the report was explained, in that it was a part of ongoing work towards identifying the point at which break-even would be achieved and developing a long term financial strategy.

24.3. DR emphasised that the actions proposed would not impact on the GPhC’s ability to meet our core regulatory obligations.

24.4. The chair of the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG) thanked the finance team for their work and assured members that following robust discussions at their meetings, the group, along with ARC, had been consulted with and included in decision making which had resulted in a progressive forward view.

24.5. The chair of ARC concurred and said that the forecasting element of the budget had been difficult but that it was crucial that it was as accurate as possible.

24.6. Members suggested a sensitivity analysis on income generation to feed into future discussions. Tarun Chotai (TC) said that work was currently underway on this with the Insights and Intelligence team.
24.7. Throughout the implementation of revalidation attrition rates were being closely monitored and risks were being managed around the possibility of more registrants leaving the register than usual.

24.8. Council agreed that, following the budget paper in March which had described future deficits, they now better understood the financial realities and could plan for them.

24.9. The Chair thanked EEAAG and reminded all that there was much work left to do.

24.10. Council agreed the revised budget for 2018/19 indicating a deficit of £1.7m and noted that work on when the GPhC would achieve budget neutrality and the development of a financial strategy was underway.

25. Performance monitoring report and annual plan progress report

25.1. DR presented 18.06.C.03, which reported to Council on the operational and financial performance against the annual plan from January to March 2018. He introduced Alicia Marsh (AM), the recently appointed Head of Professionals Regulation, to the meeting.

25.2. This paper included information about the customer contact centre that did not address the issues raised in the subsequent agenda item because it was not relevant to the quarter that was being reported on.

25.3. Members went through the report and made the following comments:

**Fitness to practise (FtP)**

25.4. DR explained that the number of concerns mentioned in the last para of 2.1 should read ‘230 a month’ and that there was an error in the calendar on page 130. A corrected graph would be circulated to members following the meeting.

**ACTION:** DR

25.5. Members discussed the decrease in cases over 15 months old at table 2.3. They asked whether there were targets in place for getting these numbers down and if so whether they were being met.

25.6. DR explained that there were a lot of case and context specific factors in cases this old but agreed that it was important to challenge. Perhaps setting targets here was part of a wider discussion on strategy in identifying what a strategic level of success might look like in FtP.

25.7. Council thought that the numbers of interim orders that had been postponed, imposed with conditions and refused were quite high. AM said that there could be many reasons for this and management continued to keep these issues under close review.
**Inspection**

25.8. Members discussed standard 4.3 in table 3.4, ‘top five standards ranked as not met’. They wondered whether there was case for separating it out as it covered both internal and external processes. If split then more useful information could be gathered.

25.9. CBS told members that when a particular issue kept coming up at inspection, it had been highlighted in Regulate and this should happen more often. Learning from inspections would feed into the knowledge hub that was being developed and could lead to themed inspections.

25.10. Council noted the first appearance of standard 2.1 in the table; which was in the scope of the recently published guidance for pharmacy owners.

25.11. Julian Graville (JG) reminded members that the numbers involved here were quite small. 2.5% of all the inspections over the three months had not met the standard. The overwhelming majority had (97.5%). These figures had high variability so that a small shift in numbers could result in a dramatic change in ranking. It was too early to draw conclusions and this would continue to be closely monitored.

25.12. The standard included staffing issues that were ongoing and occasions where the pharmacy could not open due to a shortage of staff. Members asked if there was a case for splitting out the standards to gather more detailed information. CBS said that when the standards were reviewed their configuration would be considered. The symptoms of staffing issues were being tracked to get a better idea of what was happening in this area.

25.13. Members asked for assurance around the consistency of inspections. JG said that this was a key workstream this year and initiatives had been developed around the transparency of data. Inspectors were paired with different regional managers who quality assured reports for consistency. The inspections team wanted to get this right and to be as good as they could be.

**Complaints**

25.14. Council asked when a similar table would be provided showing when concerns were closed at stage 1. CBS said that the way information was presented was being developed and said that a balance had to be struck between the right amount of data and not losing impact and focus. The ambition was to share information more meaningfully in the future and to de-couple from the performance monitoring report. Council stressed that they were keen to see this and would not want to have to wait until it was perfect.

25.15. LM also updated members on the numbers of upheld organisational complaints in quarter four.
Education

25.16. Members referred to the independent prescribing programmes and asked for more information on how much they varied and how competence was assessed. MV said that he would consider this; the current consultation on independent prescribing would provide useful information.

**ACTION:** MV

Accounts

25.17. TC advised members that the figure for creditors in the 31 March 2018 column of the statement of financial position should read 15,964.

25.18. Council discussed the current underspend and highlighted that this was not unusual. TC said that this would improve as the organisation became better at planning and profiling budgets.

25.19. **Council noted and commented upon:**

   i. The performance information provided at appendix 1; and
   ii. The report on progress against the annual plan at appendix 2

26. Implementation of online services and revalidation; and handling enquiries through the Customer Contact Centre

26.1. MV presented **18.06.C.04.** This paper provided Council with information on the number of registrants successfully signing up to online service following the launch of revalidation; the number and nature of enquiries received and how these had been handled by the contact centre.

26.2. Members agreed that it was good to see the situation so well monitored. There had not been a significant attrition rate so far, though this first cohort was quite small.

26.3. Council asked if any analytics were available on how registrants were finding using the online system – how many had logged on more than once, for example. MV said that that data was not accessible but that the impression of staff was that those who had called in and been guided through the process were satisfied.

26.4. DR linked this work with revisiting the ambition and scope of the strategic plan. It had become apparent that many registrants wanted the one to one interaction of a telephone call and this could mean that the ambition to significantly reduce telephone assistance and interact online for the majority of the time would have to be adjusted. Members pointed out that the move to more online services was a dynamic process and learning would improve with time.
26.5. Members who had tried the system out for themselves fed back that the FAQ section of the guidance was good and had enabled them to resolve any difficulties. They asked what the criteria were for temporary reduction or suspension of the customer contact centre (CCC).

26.6. MV assured members that the CCC aimed to provide consistent service from 9:00 to 17:00, Monday to Friday. The criteria under which the service may be suspended were mandatory staff training, extreme weather (when staff could not attend the office) and for extreme operational reasons. The communications would be clear about the reasons and the authorisation level.

26.7. Another point that had been taken from the situation so far was that the organisation had pockets of knowledge in staff that were not utilised and this resource could prove to be very useful.

26.8. **The Council:**
   i. Noted the progress to date on the implementation of online services and revalidation
   ii. Noted the increased numbers of telephone calls and email enquiries received by the CCC since the launch of revalidation and how these had been handled; and
   iii. Noted the plans to ensure the CCC worked effectively now and in the future.

27. Engagement and communications report

27.1. Rachael Oliver (RO) presented **18.06.C.05.** This paper kept Council abreast of engagement and communications with stakeholders via a quarterly report.

27.2. The paper included an updated list of events that members were encouraged to attend, contacting the Stakeholder Engagement Manager with their availability.

27.3. Council congratulated RO and her team for the communications on revalidation which had resulted in a high level of awareness amongst registrants.

27.4. **Council noted the paper.**

28. Remuneration Committee

   i. **Minutes of the meeting on 18 April 2018 (unconfirmed)**

28.1. Berwyn Owen (BO), chair of the Remuneration Committee, took Council through the minutes of their last meeting. The main topic of the meeting had been the approval of a holding position for the 2017/18 pay award of 2.5% across the organisation while the pay and reward system was under review. The transitional nature of this award was
emphasised; the outcome of the review would go to the committee’s next meeting in September and would then be in place for next June.

28.2. The committee had also agreed the publication of the gender pay gap report. Council welcomed the decision. They said that they would like it to come to the next meeting in July.

**ACTION:** FO

ii. **Committee’s annual report to Council including a review of their terms of reference**

28.3. There was one minor change to the committee’s terms of reference.

28.4. **Council:**

i. Noted the unconfirmed minutes of the Remuneration Committee meeting on 18 April 2018

ii. Noted the Remuneration Committee annual report 2017/18 at appendix 1

iii. Approved the updated terms of reference for the Remuneration Committee at appendix 2

29. **Audit and Risk Committee**

i. **Minutes of the meeting on the 22 May 2018 (unconfirmed)**

29.1. Digby Emson (DE) presented the minutes of the last meeting of the Audit and Risk Committee. He thanked staff for their support with what had been a complex agenda.

29.2. At 11.5. in the minutes, the committee had agreed to select and recommend to Council an appropriate oversight mechanism for increasing returns from cash deposits. Following conversations after the meeting they proposed to Council that EEAAG oversaw the process which would then be audited by ARC.

29.3. Council felt that they should have full sight of this and asked that they receive a paper on it in due course. TC assured members that a proper process would be followed. A workshop on this was being developed for members in July.

29.4. Attention was drawn to the annual internal audit opinion which states that there is an adequate and effective system of governance, risk management and internal control to address the risk that management’s objectives are not fully achieved. It was highlighted that additional wording was added to the Chief Executive’s governance statement in the annual report to clarify that there is some risk that our objectives may not be fully achieved in certain respects and that improvements are required to address those risks.

ii. **Committee’s annual report to Council including a review of their terms of reference**

29.5. There was one minor amendment to the committee’s terms of reference.
29.6. **Council:**
   
i. **Noted the unconfirmed minutes of the Audit and Risk Committee’s meeting on the 22 May 2018**
   
ii. **Noted the Audit and Risk Committee’s annual report 2017/18 at appendix 1**

iii. **Approved the updated terms of reference for the Audit and Risk Committee at appendix 2**

30. **Any other business**

30.1. The Chair drew members’ attention to the penultimate page of the consultation grid in the engagement and communications report. The House of Lords’ consultation on regulation of the internet reminded members that they should further discuss the impact of technology on pharmacy. A workshop on this would follow in the coming months.

30.2. DR said that insight and learning had been gained from the recent updated guidance on remote supply. A discussion document would be circulated to members soon.

**ACTION:** DR

30.3. The Chair thanked all members who had completed GDPR training. More updates were to come, this came under the remit of ARC.

30.4. There being no further public business to discuss the meeting closed at 15:00

**Date of the next meeting:**

Thursday 12 July 2018
Meeting paper

Council on Thursday, 12 July 2018

Public business

Council Workshop Summary

Purpose
To provide an outline note of the discussions at the June Council workshop

Recommendations
The Council is asked to note the discussions from the workshop

1. Introduction

1.1. The Council holds a workshop session alongside its regular Council meetings each month (there are no meetings in January and August). The workshops give Council members the opportunity to:
   - interact with and gain insights from staff responsible for delivering regulatory functions and projects;
   - receive information on projects during the development stages;
   - provide guidance on the direction of travel for work streams via feedback from group work or plenary discussion; and
   - receive training and other updates.

1.2. Following each workshop there is a summary of the discussions that took place, presented at the subsequent meeting. This makes the development process of our work streams more visible to the GPhC’s stakeholders. Some confidential items may not be reported on in full.

1.3. In the workshop sessions the Council does not make decisions. The sessions are informal discussions to aid the development of the Council’s views.
2. Summary of the June workshop

2.1. Strategy

Council continued discussion from the workshop in June developing the strategic vision for the GPhC. This centred around exploring the scale of ambition for the organisation. Members were asked to consider how they saw the size of the organisation in ten years’ time; they discussed fee-related issues over the same timescale.

Further areas were identified for discussion and clarification and consideration was given to what external input might be helpful for future discussions.

2.2. Exploring adopting charitable status

The objective of this session was to inform and gather the view of Council about the benefits and burdens of the GPhC adopting a charitable status from financial, legal and practical operational perspectives.

This was with a view to developing a potential formal proposal for consideration.

2.3. Update on key themes from registered pharmacies consultation

Members were told about the pre-engagement activities that had taken place before the consultation. They were updated on what was being said about the key changes suggested and the types of questions that were being raised. Comments in the press and from some stakeholders were also highlighted and discussed.

Further reports on the registered pharmacies consultation will come to workshops in the coming months to keep members well-informed on its progression.

Recommendations
Council is asked to note the discussions from the workshop

Duncan Rudkin, Chief Executive and Registrar
General Pharmaceutical Council
duncan.rudkin@pharmacyregulation.org
Tel 020 3713 8011
5 July 2018
## Council actions log

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Ref.</th>
<th>Action</th>
<th>Owner</th>
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<th>Comments/update</th>
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<tbody>
<tr>
<td>6 Jul 2017</td>
<td>31.6</td>
<td><strong>Consultation on revised threshold criteria:</strong> A report on equality, diversity and inclusion in Fitness to Practise processes would be brought to Council in due course.</td>
<td>Claire Bryce-Smith</td>
<td>Sep 18</td>
<td>Open</td>
<td>This report will be commissioned externally and will go out to tender in Jan/Feb 18. Once commissioned it is anticipated that it will take at least three months to produce the report. This is subject to applying any learning from recent reports.</td>
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<tr>
<td>9 Nov 17</td>
<td>59.9</td>
<td><strong>Registration assessment and Board of Assessors’ Report – June and September 2017:</strong> Wider data and policy issues around the Registration Assessment would be picked up in a paper to Council from the executive, out of the current reporting cycle.</td>
<td>Mark Voce</td>
<td>Jul 18</td>
<td>Open</td>
<td>This is on the agenda for today’s meeting</td>
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<td>10 May 18</td>
<td>12.2</td>
<td><strong>Minutes of the last meeting:</strong> A paper would come to a future meeting on the strategy followed to engage with patients and the public and the criteria for each approach</td>
<td>Duncan Rudkin</td>
<td>Jul 18</td>
<td>Open</td>
<td>This is on the agenda for today’s meeting</td>
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<td>7 Jun 18</td>
<td>25.4</td>
<td><strong>PMR and annual plan progress report - FtP:</strong> There was an error in the calendar on page 130. A corrected graph would be circulated to members following the meeting.</td>
<td>Duncan Rudkin</td>
<td>Jul 18</td>
<td>Closed</td>
<td>This was circulated to members on the 26 June.</td>
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<td>25.16.</td>
<td>PMR and annual plan progress report – Education: Members asked for more information on how independent prescribing programmes varied and how competence was assessed.</td>
<td>Mark Voce</td>
<td>Sep 18</td>
<td>Open</td>
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<td>This will come to Council with the formal results of the consultation on independent prescribing in September.</td>
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<td>28.2.</td>
<td>Minutes of the Rem Com meeting on 18 April 2018: Council would like the organisation’s gender pay gap report to come to the July Council meeting</td>
<td>Francesca Okosi</td>
<td>Jul 18</td>
<td>Open</td>
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<td>30.2.</td>
<td>Any other business: A discussion document on remote medicines supply would be circulated to members shortly</td>
<td>Duncan Rudkin</td>
<td>Jul 18</td>
<td>Closed</td>
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Meeting paper

Council on Thursday, 12 July 2018

Public business
Report of the Gosport Independent Panel; PSA Lessons Learned Review; and, the Professor Sir Norman Williams Review of Gross Negligence Manslaughter in Healthcare.

Purpose
This paper outlines a number of recent developments in the external context and updates the Council on our response.

Recommendations
The Council is asked to:

(a) note our response to a number of recent independent inquiries and reports within the healthcare sector; and,

(b) note the progress update on the joint work of the professional regulators and others to develop a new ‘emerging concerns’ protocol.

1. Introduction
1.1. Over the past few months, a number of important reports have been published, setting out how patients and their families have been failed or let down by healthcare professionals, regulators and other agencies, and by a wider system of regulation, which is intended to put patient safety at its heart.

1.2. Below is a brief summary of the key reports and our initial response to these.

2. Key reports

(a) Report of the Gosport Independent Panel

2.1. The Gosport Independent Panel was set up to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths. The Panel found that during a certain period at Gosport, there was a disregard for human life and a culture of shortening the lives
of a large number of patients by prescribing and administering dangerous doses of a hazardous combination of medication not clinically indicated or justified.

2.2. The full report was published on 20 June 2018 and is available here. The Panel reported that they had access to over 100,000 documents and created many others to manage its work. Most of these documents are available in the document library that sits alongside the report and are referenced throughout. Chapter 2 outlines how pharmacy services were provided at the hospital (paragraphs 2.71 – 2.79, pages 24-25) and sets out the roles and responsibilities of the pharmacists (paragraphs 3.63 -3.72, pages 68-70).

2.3. Following publication of the report, the GPhC has been working collaboratively and across the organisation to ensure that a comprehensive plan is put together for a co-ordinated response to all the pharmacy and pharmacy regulation issues to which this report relates. Council will note our high-level summary action plan setting out our key priorities in the short, medium and longer term at Appendix 1.

2.4. This action plan will be updated in light of the Government’s official response to the Gosport Report, which is expected in the Autumn 2018.

(b) PSA Lessons Learned Review

2.5. On 18 May 2018, the PSA published its Lessons Learned Review into handling by the Nursing and Midwifery Council (NMC) of concerns about midwives’ fitness to practise at the Furness General Hospital. The deaths of babies, and in some case mothers, took place between 2004 and 2016. The full report is available here.

2.6. The Review, commissioned by the Secretary of State for Health and Social Care, and supported by the NMC, has concluded that, although the NMC’s performance as a regulator is improving, it continues to make some mistakes and must develop a more respectful and open culture. The Review recognises that the NMC has made many changes and improvements since 2014, but concludes that there are two significant areas requiring additional, urgent work: the NMC’s approach to the value of evidence from and communication with patients; and its commitment in practice to transparency.

2.7. The Review also makes a series of recommendations intended to aid the NMC and other regulators to improve their standards. These are focused on ways to improve engagement with patients and the public and to act in a transparent fashion. Significant areas for all regulators include:

a. **Accurate and complete record-keeping**, to keep sight of the main issues in cases and maintain a full audit trail

b. **Identification of issues**, to ensure that investigators have the time, expertise and support, including access to clinical advice, to enable them to identify the concerns properly and to follow them through
c. **Working with third party investigators**, to ensure that they act to protect the public and that unnecessary delays are not caused by other investigations

d. **Looking beyond individual cases**, to take account of relevant information about cases and ensure intelligence is properly shared

e. **Working with others**, across the health and care system, to address concerns about patient safety

f. **Engaging with families**, to ensure they are informed of the process and progress, and that regulators analyse and take their evidence seriously

g. **Transparency**, with regulators publishing as much as they legitimately can so that they can improve public confidence through transparency and dealing appropriately with subject access requests

h. **Alternative processes**, ensuring regulators work closely with employers and other stakeholders to deal with concerns which can be remedied without fitness to practise procedures

2.8. We are working with teams across the organisation, including the fitness to practise team, to review the lessons learned in more detail and consider how these align with our current procedures, and whether any further improvements might be made. This will sit alongside our ongoing work in developing our approach to fitness to practise, which will include how we support patients and families through the process and other key elements of the report.

**(b) Williams Review into Gross Negligence Manslaughter**

2.9. On 6 February 2018, the Secretary of State for Health and Social Care announced that he was asking Professor Sir Norman Williams to conduct a rapid policy review into the issues pertaining to gross negligence manslaughter (GNM) in healthcare. The GPhC attended the evidence gathering session on 21 March 2018 and published a written brief on 6 April 2018, which informed our evidence. The Panel subsequently published its full report on 11 June 2018 and this is available here.

2.10. The report addresses the approach taken to investigations of GNM by the police, coroners and the Crown Prosecution Service (CPS), as well as the role played by expert witnesses and the challenges in finding professionals who are appropriately expert in clinical matters and competent to give evidence in Court. It also clarifies some of the recent misunderstandings around the use of health professionals’ reflective statements by the Courts or by regulators, and considers the wider involvement of regulators when dealing with fitness to practise issues.

2.11. As with the PSA report, we are considering the recommendations in more detail. Below is a summary of the key themes under which those recommendations are grouped, as well as some early reflections and indications of our proposed work in these areas:
a. **An agreed and clear position on the law on GNM**— that there is revised guidance on the investigation and prosecution of GNM in healthcare and more work to ensure there is a common understanding of the high level at which the bar for prosecution is set (i.e. ‘truly exceptionally bad’ breaches of a duty of care). The includes the creation of a working group made up of the CPS, coronial services, Treasury Council and defence organisations. We will monitor any future work in this area, and feed into this, where appropriate.

b. **Improving assurance and consistency in the use of experts in GNM cases**— that there should be training and accreditation to improve the quality and consistency of expert witnesses and that regulators should recognise acting as an expert witness as part of a healthcare professional’s revalidation or continuous professional development (CPD) process. We are supportive of this recommendation and our new revalidation processes have been designed to be flexible and to enable this to happen.

c. **Consolidating expertise of GNM in healthcare settings**— that the coronial and police services across the UK work together to consolidate expertise and ensure greater consistency in the way suspected cases of GNM are handled, and that a new memorandum of understanding (MoU) is agreed setting out the arrangements for liaison and communication in investigating these cases. We will monitor progress in this area and consider where we might play a role, potentially as a signatory to any new MOU.

d. **Improving the quality of local investigations**— that there must be a thorough local investigation of unexpected deaths in healthcare settings (in line with the NHS Improvement’s Serious Incident Framework) and that the CQC should consider the effectiveness of such investigations through its inspection programme.

e. **Reflective material**— that regulators should clarify that they will not use reflective statements in fitness to practise proceedings and that the General Optical Council and the General Medical Council should lose their legal right to demand such material. As indicated to the panel during our evidence session, we do not ask pharmacy professionals or peers to record what was discussed in their reflective accounts and instead ask them to record how the process of having a peer discussion has benefited their practice.

f. **Professional regulation**— removal of the General Medical Council’s power to appeal decisions of the MPTS to the High Court (a power which the GPhC does not hold). The panel also encouraged regulators to review and where necessary improve the support they provide to patients and family members whose care and treatment is an issue in fitness to practise proceedings.

2.12. There were also a number of recommendations for the PSA, which are relevant to our work. The Panel asked the PSA to review how the impact on public confidence is assessed in reaching fitness to practise decisions about individual healthcare professionals and to develop guidance to support consistent decision making in this area.
2.13. The Panel also asked the PSA to review the outcomes of fitness to practise cases relating to similar incidents and circumstances considered by different regulator, and to review whether the outcome of fitness to practise procedures is affected by the availability of legal representation of registrants. The latter should be considered alongside broader proposals for the reform of professional regulation, which seek to establish a less adversarial approach to fitness to practise issues through the use of undertakings and consensual disposal.

2.14. Overall, the recommendations arising from the Williams Review are timely, sensible and proportionate, and touch on fundamental principles of consistency and fairness in investigations, the need for agencies to work collaboratively, and the importance of providing support to patients and families during fitness to practise proceedings. Many of the recommendations for regulators are already covered by our existing processes. However, we are working with teams across the organisation to explore how further improvements might be made.

(c) Other future reports

2.15. The independent Inquiry following the conviction of surgeon Ian Paterson (established in January 2018) is ongoing. The inquiry will be informed by the victims and the families, and will look at lessons that can be learned from the case, and how these can improve care by the independent healthcare sector across the country. The inquiry is expected to report in Summer 2019, after which time we will review the findings and any recommendations in more detail.

(d) Other relevant work: the joint ‘emerging concerns’ protocol

2.16. In October 2016, the Health and Social Care Regulators forum (HSCRF) convened a meeting of professional regulators, system regulators and other partners to create an environment for those parties to discuss how working together as a safety system could support the delivery of the best possible care.

2.17. As regulators, we expect professionals and providers to work together collaboratively in order to provide the best possible care for patients. We hold ourselves to the same standards and recognise that sharing concerns at the right time can make it easier to identify the links to show a problem is emerging.

2.18. Under the governance of the HSCRF, the CQC led a working group to develop an emerging concerns protocol. The purpose of the protocol is to strengthen existing processes and provide a clearly defined route for organisations with a role in quality and safety of care provision to share information and intelligence that may indicate risks to users of services, their carers, families or professionals. This could include cultural issues within health and social care settings which may be noticed but would not necessarily be raised through alternative formal concerns systems. The intention is to facilitate sharing of this information at an early stage, so that links between concerns can be made, and a wider system view of the issue can be established.
2.19. The protocol is intended to be permissive and empowering, supporting regulators to understand how they can share information. It is designed to work alongside procedures that already exist and to strengthen good practice. Essentially, it is intended to help staff across the signatory organisations in making decisions as to when to escalate information of concern either bilaterally or more widely, and to ensure that a consistent approach is taken by everyone involved.

2.20. A number of healthcare regulators and other organisations have signed up to the protocol, which is due to be launched on 17 July 2018. As members of the working group, we have been involved in the development of the protocol from the outset. Going forward, regional workshops are being planned to embed this work, and to ensure that organisations are taking a consistent approach to sharing intelligence.

2.21. A confidential copy of the protocol is at appendix 2, as this is still in draft form.

3. Equality and diversity implications

3.1. The Williams Review made a number of recommendations in relation to diversity in fitness to practise proceedings, both of which form part of our existing ways of working at the GPhC.

3.2. First, the Panel supported the PSA’s intention to introduce, as part of its Standards of Good Regulation, equality and diversity standards for professional regulators. In responding to the PSA consultation, we were supportive of this change and agreed that there is great value in understanding equality data relating to our registrant body and continuing to ensure that our processes are fair. Second, the Panel recommended that regulators should ensure that fitness to practise panel members have received appropriate equality and diversity training, which is something captured within our current processes.

4. Communications

4.1. We are continuing to monitor the media and parliaments/assemblies, including parliamentary questions, debates and relevant committees across the three countries that we regulate.

4.2. Our communications team are also working with their counterparts at the CQC to ensure that the work on the emerging concerns protocol is shared and promoted to relevant stakeholders.

5. Resource implications

5.1. There are no additional resource implications associated with this work. This will be monitored in line with any future regulatory action we may need to take in response to the reports and recommendations.
6. Risk implications

6.1. It is essential that we consider the wider lessons learned, to ensure that we are regulating in a way that continues to be fit for purpose and meets the expectations of the public.

6.2. Strengthening our processes and working collaboratively with others will allow us to fulfil our roles more effectively and identify concerns at the earliest possible stage in the process. Working together can also reduce burdens by encouraging regulators to create joint plans when they share similar concerns.

7. Monitoring and review

7.1. We will provide a further update to the Council in the Autumn when the formal Government report and recommendations arising from the Gosport report are expected.

Recommendations

The Council is asked to:

(a) note our response to a number of recent independent inquiries and reports within the healthcare regulation sector; and,
(b) note the progress update on the joint work of the professional regulators and others to develop a new ‘emerging concerns’ protocol.

Laura McClintock, Chief of Staff
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4 July 2018
The Gosport Independent Panel was set up to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths. Following the publication of the panel’s report on 20 June 2018, the GPhC is working collaboratively and across the organisation to ensure that a comprehensive plan is put together for a co-ordinated response to all the pharmacy and pharmacy regulation issues to which this report relates. Below is a high-level summary action plan setting out our key priorities in the short, medium and longer term. This action plan will be updated in light of the Government’s official response to the Gosport Report, which is expected in the Autumn 2018.

<table>
<thead>
<tr>
<th>Summary Action Plan</th>
<th>Due date</th>
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<tbody>
<tr>
<td><strong>Immediate / short term priorities</strong></td>
<td></td>
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<tr>
<td>Share the report, findings and next steps with relevant GPhC teams</td>
<td>20 June 2018</td>
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<tr>
<td>Share the report, findings and next steps with Council</td>
<td>20 June 2018</td>
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<tr>
<td>Appoint an internal lead to co-ordinate the response and action plan</td>
<td>20 June 2018</td>
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<tr>
<td>Notify relevant teams about the need to prioritise and implement the action plan</td>
<td>20 June 2018</td>
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<tr>
<td>Conduct an initial review of the report to inform the action plan</td>
<td>29 June 2018</td>
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<tr>
<td>Review and collate initial statements and responses from relevant stakeholders</td>
<td>29 June 2018</td>
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<tr>
<td>Respond to any media or other enquiries</td>
<td>Ongoing</td>
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<tr>
<td>Report to Council on our initial reflections and action plan, and gather feedback</td>
<td>12 July 2018</td>
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<tr>
<td>and thoughts from members (public session)</td>
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<tr>
<td>Update Council about other related work (the responses to other recent independent</td>
<td>12 July 2018</td>
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<td>reports including the PSA Lessons Learned Review into the handling of concerns</td>
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<td>about midwives at Furness General Hospital and the Rapid Policy Review into Gross</td>
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<td>Negligence Manslaughter in healthcare)</td>
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<tr>
<td><strong>Medium term priorities</strong></td>
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<tr>
<td>Conduct a careful and comprehensive review of the report and findings, including</td>
<td>31 August 2018</td>
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<td>(but not limited to):</td>
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<td><strong>General</strong></td>
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<tr>
<td>➢ Identify and review all issues relevant to pharmacy or healthcare regulation</td>
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<tr>
<td>➢ Additional focus on the chapters relating to pharmacy services at the hospital and</td>
<td></td>
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<tr>
<td>the roles and responsibilities of pharmacists</td>
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➢ Review the issues raised about the role of pharmacists in challenging poor prescribing practices and the monitoring of pharmacy data
➢ Consider issues raised about the experiences of patients and families and how we can apply these to our work as a regulator
➢ Consider how the learnings and issues about the duty of candour and how this may feed into our ongoing work on raising concerns and embedding the standards for pharmacy professionals
➢ Consider how the failings and issues identified in the report might be handled in line with today’s regulatory framework
➢ Identify and take forward any specific actions for individuals, teams or the organisation more widely

**Fitness to practise**
➢ Review all issues raised about fitness to practise within healthcare regulation
➢ Added focus on the chapters relating the involvement of the GMC and NMC
➢ Consider the key issues raised in the report including the use of interim orders, the appropriateness of questions from fitness to practise panel members, undue delay and how accountability can be undermined by deferring to other agencies, conflicts of interests and the lack of candour in disclosing evidence of possible conflicts, failure to obtain expert evidence in appropriate cases, and a lack of communication with family members.
➢ Consider how the failings and issues identified in the report might be handled in line with today’s regulatory framework

**Collaboration and information sharing**
➢ Review the issues relating to how regulatory and enforcement agencies work together
➢ Apply the insights to how we work collaboratively with others, including sharing information through MOUs and the emerging concerns protocol

**Communications**
➢ Continue to monitor the media and parliaments/assemblies, including parliamentary questions, debates and relevant committees across the three countries we regulate
➢ Build knowledge of what other organisations are doing in response to the report and monitoring these actions
➢ Speak with key stakeholders about their plans to respond to the report and how we might work together

**Longer term priorities**

<table>
<thead>
<tr>
<th>Description</th>
<th>Due date</th>
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<tbody>
<tr>
<td>Monitor the outcome of the Government report and any recommendations</td>
<td>Autumn 2018</td>
</tr>
<tr>
<td>Update the action plan in light of any Government report and recommendations</td>
<td>Autumn 2018</td>
</tr>
<tr>
<td>Provide a progress update to Council, along with any new or amended actions in light of the Government report and recommendations</td>
<td>Autumn 2018</td>
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Meeting paper

Council on Thursday, 12 July 2018

Public business

Strategic approach to engagement with patients and the public and their elected representatives

Purpose
To set out our strategic approach to engaging with patients and the public, and with their elected representatives.

Recommendations
The Council is asked to:

- note our current approach to engaging with patients and the public and their elected representatives
- consider plans to further develop our approach going forward

1. Introduction

1.1. As an organisation, we have a statutory responsibility to consult with a range of stakeholders, including people using pharmacy services, before setting any standards or requirements under the Pharmacy Order 2010. We have made a clear commitment to consulting effectively and working closely with patients and the public and other stakeholder groups in our strategic plans and annual plans since our inception in 2010.

1.2. Our strategic plan 2017-20 emphasises that collaboration is one of our key operating principles, stating that ‘If we are to be successful, we must work alongside the people using pharmacy, the leaders of pharmacy, other regulators, and the wider health and care sector’.

1.3. These commitments have informed our four strategic aims for external communications and engagement:
• Improve the experience of people engaging with us, so they have confidence that we are an effective and efficient regulator
• Consult effectively with all key audiences, including patients and the public, to help shape the development of our standards and regulatory policies
• Engage and inform our stakeholders about our standards, the knowledge we hold and our vision for regulation, to promote improvement in pharmacy practice and care
• Gather intelligence through our strategic relationships and effective monitoring, to help the organisation to understand external changes

1.4. This paper sets out our current approach to engaging with patients and the public, and their elected representatives, and how we plan to develop that approach going forward.

2. Engagement with patients and the public

2.1. We currently engage and consult with patients and the public using a variety of methods, which are outlined below.

2.2. Using a variety of methods helps us to manage some of the challenges in relation to engaging with patients and the public. These include limited capacity and interest among patients and the public, and the organisations that represent them, in relation to pharmacy regulation and the majority of issues that we consult on. We are also conscious of making the most effective use of our limited resources for engagement.

Focus groups

2.3. We hold focus groups in England, Scotland and Wales for all major consultations. Our approach to designing, running and facilitating focus groups is based on best practice set out by the Consultation Institute.

2.4. The Consultation Institute is the leading not-for-profit best practice body operating in the field of public engagement and consultation. Its mission is to promote the highest standards of public, stakeholder and employee consultation through research, publications, specialist advice and training events in order to disseminate best practice and improve subsequent decision making.

2.5. Colleagues across the organisation who are involved in the design or facilitation of focus groups have received training from the Consultation Institute. This training focuses on how to facilitate a consultation dialogue in a focus group that meets best practice
standards. A key emphasis in this training is making sure that facilitators play a neutral role and are not leading or influencing participants towards a particular point of view.

2.6. Members of the Communications team who lead on designing focus groups have also developed significant experience through working closely with Community Research, a leading community engagement and research agency, on the development and management of previous focus groups.

2.7. We recruit participants for focus groups both through a market research agency, which recruits a broadly representative sample of the public, and through organisations representing patients and the public with which we have developed close working relationships, including Tower Hamlets Parent and Carer Group and the Alliance in Scotland.

2.8. Facilitators are asked to write up the feedback received in a format recommended by the Consultation Institute, and this is then collated, analysed and summarised in a written report. This is then included in the consultation feedback for analysis.

2.9. Previously, these reports have not been published separately, but instead the key points have been summarised in a section in the consultation report. Going forward, we are proposing to publish the focus group reports on our website in order to make sure that all stakeholders can read the full summary of the feedback received through these focus groups.

2.10. Focus groups we have held have regularly influenced our standards, guidance and policies. For example, throughout the revalidation development programme, we convened patient focus groups to help inform policy development. The views gathered in these focus groups influenced our policy design. For example, we maintained a difference between planned and unplanned learning because of the different perceptions that members of the public have compared to pharmacy professionals on the value of these different types of learning.

Patient representation on advisory groups

2.11. For areas of major policy development, such as revalidation or education, we establish advisory groups and seek to include at least one patient representative on each advisory group.

2.12. The revalidation advisory group included a patient representative who provided a valuable and challenging perspective on behalf of patients and the public and played a significant role in the development of the final framework. For example, the patient representative made the case that the peer in the peer discussion could potentially be a patient, if they had the necessary understanding of the pharmacy professional’s practice, and this is reflected in the revalidation framework and peer discussion guidance.
2.13. We are currently in the process of beginning to recruit patient representatives for our Education Advisory Panel. To make sure the process for recruitment is fair and transparent, we will be advertising the opportunity on our website and promoting it via our networks. We will then hold interviews with applicants who meet the criteria.

2.14. We intend to use this process for recruiting all future patient representatives. We also intend to recruit two patient representatives for each advisory group, to provide peer support for each patient representative and to strengthen the voice of the patient in each group.

Research and polling with members of the public

2.15. We also carry out research and polling with the public to help us understand their views and perceptions and to inform our work.

2.16. We have commissioned a leading market research agency to carry out a poll of a representative sample of adults across Great Britain to seek views on key proposals within our consultation on developing our approach to regulating registered pharmacies. The results will be included in the consultation analysis.

2.17. The Data and Insight team are planning to commission a public perceptions survey in relation to pharmacy in the next financial year in order to promote improved understanding of public expectations. This would follow on from a previous survey we commissioned in 2014 and which was published in 2015.

Engagement with organisations representing patients and the public

2.18. We have developed an effective network with a wide range of organisations which represent patients and the public.

2.19. This network includes Healthwatch in England, the Alliance in Scotland and Community Health Councils in Wales, which represent the views of the users of health services in each country. Their local knowledge, experience and contacts with users of pharmacy services are useful in informing our policy development work.

2.20. We also engage with a range of organisations that represent patients and the public with particular conditions and/or with protected characteristics, and tailor our engagement for each consultation or other activity.

2.21. We engage with this network in a variety of ways, including through 1-2-1 meetings and targeted emails on key issues (for example when developing the guidance on religion, values and beliefs). We also develop a toolkit of resources, such as newsletter articles and social media posts, for all key engagement activities to support these organisations to
share information with their members.

3. **Engagement with elected representatives across Great Britain**

3.1. We engage with parliamentarians and other elected representatives in England, Scotland and Wales through a range of channels, including through meetings, written briefings and through disseminating our annual report.

3.2. We also regularly work with the governments in the three countries we regulate to provide responses to parliamentary questions which are relevant to our work, and monitor for key developments within parliaments and assemblies across Great Britain.

3.3. We have recently put in place a new public affairs plan for 2018-19 which sets out how we will engage with political stakeholders and elected representatives throughout Great Britain over the next year.

3.4. This plan sets out an intention to expand our public affairs activity to increase our ability to inform and influence the agenda on key issues relating to our role (including issues relating to Brexit), and to make sure parliamentarians understand our role as they consider how health and social care, and how they are regulated, develop in the future.

3.5. This plan was developed following discussions with the Chair and Chief Executive, as well as the Directors for Scotland and Wales.

3.6. In the plan, we have outlined the following key objectives:

- Develop effective working relationships across the political spectrum in Great Britain.
- Enhance the reputation of the GPhC as a source of strategic advice and support by governments and opposition parties, relevant Committees, parliamentary groups, parliamentarians, civil servants and officials across the three countries.
- Increase recognition among key political stakeholders across the three countries, of the GPhC as an effective and proactive regulator.
- Expand our network of political stakeholders with whom we can collaborate on issues of mutual interest. These groups to include other regulatory bodies, patient groups, charities, unions and professional representative groups across the three countries.
- Provide strategic advice across the organisation, with colleagues proactively advised and supported on political developments.

3.7. The plan sets out how we will engage with parliamentarians over the next year, across the three countries that we regulate, by
• preparing and disseminating written briefings on key issues to targeted individuals
• participating strategically in relevant governmental or committee enquiries as they arise
• responding appropriately and effectively to parliamentary questions, political correspondence and FOIs as they arise
• attending key events, conferences and meetings in Parliament and in the devolved administrations, including engaging with appropriate committees and all-party groups
• attending political party conferences where appropriate, and arranging meetings with AMs, MSPs MPs and other stakeholders.

3.8. As part of our work to deliver this plan, we have arranged a number of meetings, including with:

• Steve Brine MP, Parliamentary Under Secretary for Health
• Kevin Barron MP, Chair of the all-party pharmacy group
• Jonathan Ashworth MP, Shadow Minister for Health
• Vaughan Gething AM, Cabinet Secretary for Health, Wales
• Shona Robison MSP, Cabinet Secretary for Health, Scotland
• Anas Sarwar MSP, the Scottish Shadow Cabinet Secretary for Health and Sport
• Maree Todd MSP, Minister for Childcare and Early Years in the Scottish Government (and a registered pharmacist)

3.9. The Public Affairs Manager and Head of Communications will continue to work closely with the Chair and Chief Executive and the Directors for Scotland and Wales surrounding our approach to public affairs going forward. We have set up a regular bi-annual meeting to discuss this work as it continues.

3.10. We will also be briefing the Council on this work as part of the Head of Communications’ quarterly report to Council. The Head of Communications and Directors for Scotland and Wales will also provide updates on key developments at Council workshops on an ad hoc basis.

4. Equality and diversity implications

4.1. A key focus in all of our communications and engagement work is to make sure that we are effectively engaging with all groups of stakeholders, including people with protected characteristics
4.2. We monitor the diversity of the focus groups and other engagement events that we hold, and make sure all of these events are accessible to those attending them.

4.3. What we learn through our engagement with patients and the public, and the organisations that represent them, is then considered as part of our equality impact assessments.

5. Resource implications

5.1. The communications and engagement activity outlined in this paper has been budgeted for in the 2018-19 budget.

6. Risk implications

6.1. Failure to effectively engage with patients and the public, and their elected representatives, would have a significant impact on our ability to meet our statutory obligations, our reputation and the quality of our standards, guidance and policies.

7. Monitoring and review

7.1. We evaluate our engagement with patients and the public and elected representatives for each significant consultation or project. The learnings identified through these evaluations then informs future approaches to engagement.

Recommendations

The Council is asked to:

• note our current approach to engaging with patients and the public and their elected representatives

• consider plans to further develop our approach going forward

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2 July 2018
Meeting paper
Council on Thursday, 12 July 2018

Public business
Rebalancing Medicines Legislation & Pharmacy Regulation: Consultation

Purpose
To update the Council on the government consultation ‘Rebalancing medicines legislation and pharmacy regulation’.

Recommendations
The Council is asked to note the update on the government consultation and our approach to, and participation in, the consultation.

1. Introduction
1.1. The programme board for ‘rebalancing’ medicines legislation and pharmacy regulation was tasked with examining the respective scope of legislation and regulation, and the interface between them, with a view to ensuring these are optimally designed to provide safety for users of pharmacy services, while facilitating and reducing the barriers to responsible development of practice, innovation and a systemic approach to quality in pharmacy.

1.2. The four UK health departments launched a consultation seeking views on two pharmacy related section orders on 19 June 2018. The consultation closes on 11 September 2018.

1.3. The GPhC is a member of the rebalancing programme board and has had input into the proposals set out in the consultation. It is important to be clear that the rebalancing board was tasked with providing advice to ministers; the current consultation is not the board’s but the government’s consultation following advice.

2. The consultation proposals
2.1. The rebalancing consultation consists of two s60 orders:
   2.1.1. Amending dispensing error legislation for hospitals and other pharmacy services
2.1.2. Making changes to the superintendent and responsible pharmacist framework

**Dispensing error legislation**

2.2. The s60 order seeks to amend the Medicines Act 1968 to extend the defences to pharmacy professionals working in hospital pharmacy services (whether or not the activity is undertaken from a registered pharmacy), and in other relevant pharmacy services. The proposals do not cover errors made where medicines are supplied as part of licenced manufacturing activity where based, for example in aseptic preparation units.

2.3. These proposals are similar to, but separate from, those that were previously consulted on for pharmacists and pharmacy technicians working in registered pharmacies.

2.4. The following conditions must be met in order for the defence to apply:

2.4.1. The person who dispensed the product was a registrant, or was acting under the supervision of a registrant

2.4.2. The medicine must be supplied in the course of the provision of a relevant pharmacy service

2.4.3. The registrant was acting in the course of their profession

2.4.4. The medicine was dispensed in pursuance of a prescription/directions or under the recognised arrangements for emergency supply without a prescription/directions

2.4.5. The pharmacy professional did not know that the product had been adulterated or was not of the nature and quality intended and

2.4.6. The patient was promptly notified of the error, unless considered unnecessary

2.4.7. The pharmacy service is overseen by a ‘chief pharmacist’

2.5. Unlike registered pharmacies, hospital pharmacies do not routinely need to be registered with one of the pharmacy regulators. In addition, there is no uniform system of governance or registration and inspection regimes across the four UK countries in respect to health care.

2.6. It is proposed to include as part of the necessary system governance the role of a “Chief Pharmacist”, who is to be the person who is responsible for the safe and effective running of the pharmacy service. The proposed Chief Pharmacist should be a “senior manager” with “authority to make decisions that affect the running of the pharmacy service”. This aligns with the proposals for the role of the superintendent pharmacist covered later in the paper.

2.7. If a pharmacy service that potentially is covered by the extension of the defences does not in fact have a Chief Pharmacist, registered pharmacy professionals working for that service will not benefit from the extension of the defences.
2.8. Therefore, although having someone performing the role of Chief Pharmacist isn’t mandatory for any broader purposes; there is a significant incentive for pharmacy services to have someone in that role – and to have the governance arrangements that go along with it.

2.9. In summary, it is proposed that the Chief Pharmacist should:

   2.9.1. be a registered pharmacist;
   2.9.2. play a significant role in the making of decisions about how all or a substantial part of the pharmacy services’ activities is to be managed or organised; or alternatively manage or organise the whole or a substantial part of those activities; and
   2.9.3. have authority to make decisions that affect the running of the pharmacy service so far as concerns the sale or supply of medicines and be responsible for securing the safe and effective running of the pharmacy service.

2.10. It is also proposed to enable the pharmacy regulators to set professional standards for Chief Pharmacists, including a description of their professional responsibilities.

**Superintendent pharmacists (SP)**

2.11. The proposals seek to clarify the role of the SP which will reflect at corporate level the role of the RP in a particular pharmacy on a particular day.

2.12. The consultation proposes:

   2.12.1. The SP is a senior manager in the retail pharmacy business who ‘has the authority to make decisions that affect the running of the retail pharmacy business so far as concerns the retail sale of medicinal products and the supply of such products in circumstances corresponding to retail sale…..’

   2.12.2. It should no longer be a requirement for a SP to be on the board of a pharmacy business and therefore the restriction for companies with ‘chemist’ in their title to have the SP as a member of the board will be removed

   2.12.3. To introduce a new general duty for the SP to secure the safe and effective running of the retail pharmacy business so far as concerns the retail sale and supply in circumstances corresponding to retail sale of all medicines by that business.

   2.12.4. That the role of the SP extends beyond the sale and supply of medicines to other services, such as clinical and public health services. The proposed way of achieving this is to give the pharmacy regulators the powers to include in standards a description of the professional responsibilities of the SP
2.12.5. The current restriction that an SP can only be SP for one retail pharmacy business should be removed from legislation and will be a matter for the pharmacy regulators.

2.12.6. To provide the pharmacy regulators with a new power that makes it clear they can set professional standards specifically for SPs.

**Responsible pharmacists (RP)**

2.13. The current requirement for an RP to be in charge of each pharmacy, alongside the current statutory duty in relation to the safe and effective running of that pharmacy will be retained. However, the consultation makes a number of proposals in relation to the role of the RP. These include:

2.13.1. Clarity that the statutory duty is engaged only for the time that the RP is designated as such.

2.13.2. Clarify the nature of activities that trigger the need for an RP.

2.13.3. Clarify the duties of RP relate to services ‘at or from’ a particular pharmacy premises.

2.13.4. Pharmacy regulators should set out the detail of the RP’s statutory responsibilities in Rules, instead of primary legislation or Ministerial regulations. It is proposed that transitional provisions would be made to preserve the current RP regulations until each regulator has made their first set of rules.

2.13.5. The current Ministerial regulation making power to make an exception to the general rule that a RP can only be in charge of one pharmacy at a time will be replaced with a pharmacy regulator rule making power.

2.13.6. The current duty for the RP to establish, maintain and review procedures will be removed.

2.13.7. The pharmacy regulator will be able to make record keeping requirements as necessary through the Rules making provisions.

2.13.8. Current legislation provides for Ministers to make regulations in relation to an RP’s absence from the pharmacy, the current limit is a maximum of two hours absence. It is proposed that pharmacy regulators will be able to address this in future Rules.

2.13.9. It is proposed that before making Rules, the GPhC must publish draft Rules and invite representations from Ministers and other appropriate persons to consult on the draft rules. In Great Britain, the resultant rules cannot enter into force until
approved by the Privy Council and will then be subject to the “negative resolution” scrutiny procedure in the UK Parliament.

2.13.10. The pharmacy regulators will be provided with a new power to set professional standards for RP’s.

2.14 The proposed changes to the SP and RP responsibilities are a welcome opportunity to better align legal accountability with actual responsibility and control. For example, the proposed removal of the RP’s responsibility to establish, maintain and review standard operating procedures.

3. Developing our response

3.1. Our response to the consultation will reflect the GPhC strategy and the Council’s commitment to providing assurance and playing its part in improving quality in pharmacy.

3.2. We will also welcome changes that will increase reporting, learning and improvement in the delivery of pharmacy services as a result of removing the fear of prosecution. Our response is likely to mirror what we said in the previous consultation to introduce a new defence for pharmacy professionals working in registered pharmacies.

3.3. Our response to the superintendent and responsible pharmacist proposals will explain the way we develop evidence based policy in collaboration with patients and the public, stakeholders and those we regulate.

3.4. Our response will not seek to make policy decisions about the content of any future standards or Rules.

4. Equality and diversity implications

4.1. We do not see any specific equality and diversity implications arising specifically out of our response to the consultation.

4.2. We remain committed to upholding the core principles of equality and diversity and meeting our ongoing obligations through the Equalities Act 2010. If the s60 orders proceed we will need to consider equality and diversity implications as we move forwards with our work to develop new regulatory standards for SP and RP, as well as new RP Rules.

5. Communications

5.1. The response to the consultation is an opportunity to explain our approach to regulating both pharmacy professionals and registered pharmacies. It also provides an opportunity to
restate our commitment to developing evidence based policy and standards in collaboration with patients and the public and the pharmacy sector.

5.2. The response to the consultation will be published on the GPhC website.

6. **Resource implications**

6.1. There are no additional resource requirements.

7. **Risk implications**

7.1. There are no specific risk implications associated with our response.

8. **Monitoring and review**

8.1. The outcomes from the consultation will be monitored and reviewed.

**Recommendations**

To update the Council on the government consultation ‘Rebalancing medicines legislation and pharmacy regulation’.

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Tel 020 3713 7958

5 July 2018
Meeting paper
Council on Thursday, 12 July 2018

Public business
Learning from the Registration Assessment 2010-2018

Purpose
To provide Council with 1. a summary of developments in the Registration Assessment 2010-2018, 2. summary findings of candidate performance and 3. suggested actions based on the findings.

Recommendations
Council is asked to provide feedback on the three next steps in section 5 of this paper.

1. Introduction
1.1. When the GPhC became the regulator in 2010, it adopted the former regulator’s standards for pharmacist registration, including a national examination. This paper discusses 1. the changes made to that examination since 2010, 2. what has been learnt about candidate performance, and 3. suggests next steps based on performance analyses.
1.2. The journey to registration as a pharmacist in Great Britain for GB-trained and non-EU/EEA-trained pharmacists is either an MPharm degree or Overseas Pharmacists’ Assessment Programme (OSPAP) followed by 52 weeks of pre-registration training and a national examination, the Registration Assessment.
1.3. The modern version of the Registration Assessment began in 1993 and was modified substantially in 2016 by the GPhC to focus on clinical care, patient-centred practice and more realistic pharmaceutical calculations.

2. Changes to the Registration Assessment
2.1 In 2010, the early Registration Assessment priorities for the GPhC were to recruit a new cadre of pharmacist question writers to replenish its question bank with additional questions about contemporary clinical practice and to strengthen the Board of Assessors, the expert group that sets and oversees the Registration Assessment on behalf of the GPhC, by recruiting additional pharmacist practice members, additional pharmacist
academic members and adding experts in healthcare assessment practice. With this achieved, in 2014 the GPhC then turned to the format and content of the Assessment itself.

2.2 The Board of Assessors refreshed the syllabus for the Assessment, recasting it as the Registration Assessment Framework, and set a clear direction towards calculations questions based on realistic patient scenarios and practice questions based on clinical scenarios likely to be encountered by an early years pharmacist. The changes were agreed by the Board in 2014, announced in 2015 and the first candidates sat new style papers in June 2016.

2.3 As an additional quality assurance measure, the Board introduced question standards setting by a group of pharmacists with current experience of pre-registration training, the standards setters. They set the standard of each question and agree a pass rate for it (the percentage of candidates likely to answer the question correctly). The pass rates for the questions in a paper are then aggregated to generate the draft pass mark for the paper.

2.4 In parallel with the Board’s developments, the GPhC developed its approach to analysing the results of sittings and to publishing data. In 2013, the GPhC began to publish aggregate candidate performance data by age, sex, ethnicity, country of pre-registration training, sector of pre-registration training, number of sittings\(^1\) and school of pharmacy attended. In 2016, complete sets of anonymised candidate performance data for sittings and performance data by pre-registration training provider were added. These data releases, with accompanying analyses, complement reports on sittings from Board of Assessors to Council.

2.5 As part of our commitment to good governance, in 2017 we commissioned an independent review of the Board of Assessors’ role, remit and governance processes. We will be following up the recommendations in that report in 2018-2019.

2.6 Returning to candidate performance, the following section summarises what we have learnt from running the Registration Assessment.

### 3. Learning from the Registration Assessment

3.1. There are two overarching learning points from our analysis of candidate performance:

- the data paint a consistent picture of performance year on year analysed by characteristics (those listed in 2.4); and

- when people are competitively selected in to a part of initial education and training their chances of passing the Registration Assessment tend to be higher than those who are

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\(^1\) The maximum number of attempts permitted is three.
recruited. In this context, selection is where there are more applicants for a place at university or in training than there are places (demand exceeds supply) and recruitment is where places may not be filled because there are more places available than committed applicants (supply exceeds demand).

3.2. Turning to candidate performance by characteristics, the data suggests the following, consistently:

- **Age:** Most trainees are in the age bracket 18-25, with smaller numbers in 26-35 and smaller numbers still 36 or older. The strongest performing cohort is the youngest, with a decline after 25 and a more pronounced decline after 35. We have not explored age-related performance issues in depth but mature trainees who completed the surveys discussed in section 4. below did report that they felt undervalued and that pre-registration tutors did not value or take advantage of the life experience they brought to their training.

- **Sex:** In general women perform slightly better than men but there is not a significant difference.

- **Ethnicity:** There is a marked difference in performance by ethnicity. For some groups, pass ranges have been consistently in the 80-95% bracket, whereas for others the bracket is 50-69%. Through our analyses we noted that the performance of Black-African candidates tended to be low and to explore why this might be the case we commissioned independent research into their experience of pre-registration training. The picture was a mixed one in that some candidates achieved good A levels, went to selective universities and secured pre-registration training places by open competition. For them, pre-registration had been a positive experience; for others, who had struggled in training, it was not so much that one factor had contributed to an unsatisfying experience, rather it was a combination of them. Some trainees were older with family and financial responsibilities in the UK and elsewhere, which limited their mobility and choices when applying for university or a training place. Added to that, they were less able to participate in out-of-hours social activities which led to exclusion from other groups linked to the course and to a feeling of isolation. Both as students and trainees, people felt that they had been ignored or, rather, that lecturers and tutors prioritised others over them. Finally, in some cases they also experienced overt racism.

- **Country of pre-registration training:** Scottish- and Welsh-trained candidates outperform English ones consistently. In Scotland there is a selective, funded pre-registration training scheme, in Wales, selection predominates but the profile is mixed in England. While we must be careful not to make cause and effect statements, we think it is justifiable to suggest that candidates who are selected in to managed schemes tend to perform well in
the Registration Assessment, partly because they are supported and developed while training.

- Sector of pre-registration training: The two sectors with statistically significant cohorts are hospital and community and hospital-trained candidates always outperform community-trained ones. Linking this to the overarching selection/recruitment observation, all hospital trainees are subject to a selection process and enter a managed training scheme, in contrast to community where the pattern is mixed.

- Pre-registration training providers: Since 2016 we have published candidate performance data by pre-registration training provider, where there are sufficient trainees to ensure anonymity. There is variation between providers and we know from discussions with some training leads that poor performance by a cohort has led to their company investing more in pre-registration training. As a next step we are proposing to contact pre-registration training providers to understand their training schemes in more detail, particularly from an equality and diversity perspective.

- Number of sitting attempts: Our intuitive assumption that the pass rate for candidates who pass the Registration Assessment on first attempt should be higher than those who resit has proved to be correct: pass rates for first time sitters can be 20%+ higher than for second and third attempt sitters. We undertook a limited amount of research in to the profile of second and third sitters, which revealed it can be the case that the MPharm entry scores for such candidates are comparatively low, that they may have failed modules or retaken years while at university and that they may have changed training provider after failing the Registration Assessment for the first time (the most consistent pattern being that hospital/industry candidates who fail transfer to community). Failing the Registration Assessment is not an isolated, unexpected event for those individuals.

- School of pharmacy attended: In recent years the number of schools of pharmacy have increased and with that so has the number of candidates sitting the Registration Assessment. The data show that irrespective of the overall pass rate for a sitting, the rank ordering of schools by pass rate remains broadly consistent year on year. Another feature of achievement measured by school of pharmacy attended is that as the number of schools has increased, the bottom end of the mark range has lowered, extending the range overall.

- In June 2016 Council noted that candidates from some schools had performed poorly in comparison to others so we invited representatives from those schools to discuss the issue with us. The schools’ own analyses of candidate performance were frank and honest, in our opinion, and the main points they had in common were:
that their institutions were committed to widening access, which meant that in the overall student mix there were those who had been recruited locally with non-traditional/weaker educational backgrounds. In the schools' view, even if those students did not perform as well as more advantaged students from other schools, giving them a chance to succeed they might not otherwise have was justifiable in itself; and

that some students did not expect to be high achievers: they had attended a local school, studied at university locally and expected to train and work as a pharmacist there as well. To break the cycle some schools have employed pharmacists from modest backgrounds who have become high achievers as ‘aspiration champions’ role models. The schools reported that this approach was having some success in encouraging students to consider making realistic applications for more challenging pre-registration placements.

June vs September sitting: the two sittings of the Registration Assessment every year are in June and September and the cohorts for the two are different: June comprises predominantly first sitting candidates whereas September is split 50/50 between first sitters and second/third sitters. This concentration of resitting candidates in September has tended to depress the overall pass rate for September cohorts.

3.3. Unless there is a significant change in the profile of pre-registration trainees, or in the delivery of a training scheme, we expect future analyses to reveal the same trends.

3.4. Our analyses have been revealing and we are mindful that they only refer to pharmacist candidate performance. There is no equivalent examination for pharmacy technicians so the Education and Data and Insight teams have been working on a data collection strategy for pre-registration trainee pharmacy technicians to achieve a similar outcome.

4. Pre-registration training surveys

4.1. In 2012/13, 2013/14 and 2014/15 we commissioned pre-registration trainee and tutor surveys of their experiences of pre-registration training. Also in 2012/13 we commissioned a follow-up analysis of trainee dissatisfaction.

4.2. The surveys showed consistently that c.80% of trainees were satisfied with their training, with higher satisfaction rates in Scotland and Wales compared to England. Satisfaction rates were higher among Hospital trainees compared to their Community counterparts.

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2 https://www.pharmacyregulation.org/pre-registration-trainee-survey-2013,
https://www.pharmacyregulation.org/resources/research/pre-registration-survey-2014,
https://www.pharmacyregulation.org/resources/research/pre-registration-survey-2015,
https://www.pharmacyregulation.org/pre-registration-surveys-2016
Put another way, satisfaction was highest among trainees in selective, managed training schemes.

4.3. After the first survey in 2012/13 we commissioned a more detailed analysis of the dissatisfied 20% of trainees and found them to be concentrated in England, particularly London, and in Community pharmacy. Also, some, but by no means all, dissatisfied trainees were mature. Common concerns among dissatisfied trainees were poor tutoring, a lack of supervision and a lack of study time.

4.4. Although we have no means of linking the anonymised survey respondents directly to cohorts of Registration Assessment candidates, it is striking that the profile of some unsuccessful candidates and dissatisfied trainees are similar.

5. Next steps

5.1. We have reached the point where our data are presenting a consistent profile of candidate performance in the Registration Assessment. We will continue to report on performance but the more important point now is how we use the data moving forward. While the data is linked to candidate performance in an examination, that examination is part of a five-year continuum of initial education and training. For most people, the MPharm degree may be separate from the pre-registration training year but achievement at either stage would seem to have an impact on performance in the Registration Assessment.

5.2. A consistent theme in this paper has been variability in performance by candidates and, linked to that, equality of opportunity. It seems logical, therefore, that the actions arising from our data analysis – rather than from longer-term issues around the role of the regulator in assessment3 – should focus on equality and diversity. With that in mind we have identified three actions for us to take forward which we think build effectively on what we have learnt from our analyses:

1. redraft our current initial education and training standards for pharmacists to require schools of pharmacy to have proactive equality and diversity policies and for schools to report on the implementation of them through accreditation. This will form part of our general redrafting of these standards scheduled for later this year. This will bring those standards in to line with our 2017 initial education and training standards for pharmacy technicians which have been rewritten with an emphasis on the need for proactive

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3 The role of the regulator in national assessments for both pharmacists and pharmacy technicians has been agreed by the Senior Leadership Group as a strand in our workstream Assuring Quality in Education.
equality and diversity policies. We intend to engage with designers and providers for courses based on those standards in the same way through accreditation;

2. linked to the previous action, draw out equality and diversity as a theme in accreditation events in 2018/19, 2019/20 and 2020/21, in the first instance, and present a report on our findings to Council for further consideration; and

3. engage with pre-registration training providers to discuss their equality and diversity practices and prepare a report on our findings for Council for further consideration.

6. **Equality and diversity implications**

6.1. Equality and diversity issues have been discussed throughout the paper.

7. **Communications**

7.1. There are no communications needs arising from this paper.

8. **Resource implications**

8.1. The standards development and accreditation work and work with pre-registration training providers will be resourced from within existing budgets.

9. **Risk implications**

9.1. The risk is somewhat diffuse and possibly systemic: that without an understanding of, and commitment to, equality and diversity issues among the providers of initial education and training, students/trainees with the potential to become pharmacists may never realise that potential and may be lost to the system and to the profession.

10. **Monitoring and review**

10.1. The publication of the two analytical reports identified in the Next Steps section will enable us to review current equality and diversity practice in pre-registration training and both monitor and review equality and diversity practice in schools of pharmacy.

**Recommendations**
Council is asked to provide feedback on the three next steps in section 5 of this paper.
Damian Day, Head of Education
General Pharmaceutical Council
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4 July 2018
Meeting paper
Council on Thursday, 12 July 2018

Public business

Monitoring and governance of revalidation for pharmacy professionals

Purpose
To ask the Council to agree an approach to monitoring and governing revalidation for pharmacy professionals following its implementation.

Recommendations
The council is asked to agree the following:

- To approve revisions to the governance structure for revalidation including the disestablishment of the Council assurance group for revalidation
- To approve new terms of reference for the advisory group (appendix one)

The council is asked to note the forward plan for Council engagement on revalidation (appendix two).

1. Introduction

1.1. The design of the monitoring and governance for revalidation for pharmacy professionals was initially designed to be suitable to development of policy and procedure through comprehensive research and stakeholder engagement.

1.2. Now that revalidation for pharmacy professionals has moved into phased implementation, it is time for Council to agree a revised form of monitoring and governance that is tailored to the new activities.

1.3. This paper describes the new proposals for monitoring and governance and seeks Council’s approval for them.
2. The previous governance structure and the work it governed

2.1. The Council was the decision-making body.

2.2. The Council assurance group was a mechanism for Council to give additional time to scrutiny the development of the revalidation framework and accordingly provided greater assurance to the wider Council when decisions were made on future policy.

2.3. The advisory group was the route through which external stakeholders were involved in the development of the revalidation framework. The advisory group played a role in steering the approach taken to development and also communications and engagement. Council members were invited to attend advisory group meetings and workshops as observers.

2.4. Implementation was governed through organisational business planning and monitoring processes which included specific project management monitoring.

2.5. This model of governance was tailored to the phases of activity required for development and early implementation of revalidation. In these phases, the Council needed specific forms of assurance to support their decision making related to the following areas:

- Quality of the evidence being presented to support decision making.
- Breadth and depth of engagement with members of the public, pharmacy professionals, their employers and representative bodies.
- Delivery of the phases of the project to the agreed timetable and budget.
- That the model would embody the principles the Council agreed for revalidation.

3. The proposed governance structure and the work it will govern

3.1. Now that the activities related to revalidation are different, it is proposed that a new governance structure will be more appropriate. Less time is required for Council to receive assurance and therefore the governance structure is simpler and has fewer layers. More time will be spent engaging directly with organisations supporting registrants with the resources that are made available.

3.2. The proposed governance structure comprises:

- Council will continue to be the decision-making body. The Council assurance group will be disestablished because additional scrutiny time is no longer required above the available time at council meetings and workshops.
- The advisory group will be the route through which external stakeholders are involved in evaluating the revalidation framework. The advisory group will meet less frequently because there will be less work required. The group will no longer require an independent Chair but the former Chair will still be invited to workshops as a member of the group.
• Delivery of phased implementation of revalidation and evaluation will be governed through organisational business planning.
• External stakeholder groups will be set up to support organisations who are supporting registrants directly. This will ensure all groups are communicated with fairly and consistently.

3.3. The work that needs to be governed is related to:
• Designing and delivering an evaluation exercise.
• Supporting organisations to support registrants in meeting the requirements of revalidation.
• Completing IT development to enable registrants to submit revalidation records and have them reviewed.
• Appointing additional revalidation reviewers and training all the reviewers for their new role.

4. Equality and diversity implications
4.1. There are no direct impacts to individuals or groups as a result of the proposals in this paper.

5. Communications
5.1. The proposals do not require widespread communication, but information will be made available on our website and communications will be sent directly to organisations represented on the advisory group.

6. Resource implications
6.1. The resources required to support the proposed governance structure are minimal and have been accounted for in annual planning.

7. Risk implications
7.1. There are no direct risk implications as result of adopting the proposed model of governance. The model of governance will continue to allow for appropriate management of risk that arises from phased implementation of revalidation for pharmacy professionals.
8. Monitoring and review

8.1. The proposed governance structure provides the opportunity for Council to monitor and review revalidation for pharmacy professionals. The forward plan (appendix 2) sets out Council’s timings of Council’s involvement.

Recommendations

The council is asked to agree the following:

- To approve revisions to the governance structure for revalidation including the disestablishment the Council assurance group for revalidation
- To approve new terms of reference for the advisory group (appendix one)

The council is asked to note the forward plan for Council engagement on revalidation (appendix two).

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27 June 2018
Appendix one – Terms of reference for the advisory group

Revalidation advisory group

Terms of Reference

Background

1. The Council established an advisory group at its meeting on 11 September 2014 to support the development of revalidation for pharmacy professionals. Following implementation of revalidation in 2018, the group’s role changed to support implementation and evaluation. These terms of reference set out the role and operation of the advisory group.

Role

2. The group will, using the principles for revalidation (see annex one) as a guide, provide advice to the executive and assurance to Council on the implementation and evaluation of revalidation for pharmacy professionals, including:

   a. Providing feedback from organisations on the impact of implementation.
   b. Testing communications and engagement with registrants and their employers.
   c. The design of an evaluation approach for the short and long-term analysis of impact.
   d. Making suggestions for improvements to the revalidation framework based on evaluation.

Composition

1. The members of the advisory group will be drawn from external stakeholders to the GPhC. Nominations for members will be sought from stakeholder organisations.
2. The group will be divided into attending and corresponding members. Attending members will be invited to meetings and all other forms of engagement. Corresponding members will receive papers for meetings and be invited to all other forms of engagement.
3. As much as possible, the membership of the attending members group will be small to facilitate effective decision-making. The corresponding group membership will not be capped so the maximum number of stakeholder organisations can be involved.
4. A broad representation of stakeholders will be invited into the membership to include the following groups:
   - Pharmacists
• Pharmacy technicians
• Employers across a range of contexts of pharmacy practice
• Patients and the public
• Training providers
• Commissioners / funding bodies
• Unions
• Students and trainees

5. The group may also wish to invite other parties to attend meetings or engagement activities, such as other regulators (both professional and systems), or subject matter specialists.

**Frequency and format of meetings**

6. Up to two workshops per year will be used to engage the group. Workshops will be 2 hours long.
7. Other methods of engagement will include: online engagement, email and telephone.
8. All meetings and engagement with the group will account for no more than a total of three working days for each member of the group.
9. Notes from may be kept from workshops but comments from members will not be attributable to individuals.
10. Business of the meetings will be treated as public and records may be subject to Freedom of Information Requests.

**Duration and review of role**

11. The group will operate for one year following implementation of revalidation and GPhC will review the group’s role and the requirement for future workshops on an annual basis.

**Expenses**

12. Reasonable expenses for attendance at meetings will be paid in line with the GPhC expenses policy.
13. Accommodation bookings should be made through GPhC staff when required to ensure the best available price is achieved.
Annex one

Principles for revalidation

1. The primary role of revalidation for pharmacy professionals is to reaffirm registrants continue to meet the core standards for pharmacy professionals.

The framework will seek to have a positive impact on the behaviours and development of professionals and will not pursue a fixed point assessment. Assurance will be based on affirming the core standards for safe and effective pharmacy practice on a continuous basis by driving behaviours toward engagement with professional responsibilities for maintaining and developing professional knowledge and skills through reflection and collaboration.

2. The framework will need to take account of the full range of roles and settings of pharmacy practice and as a result be based upon a common standard and flexible process and evidence requirements.

Additional assurance must be received from external sources and be related to a registrant’s current context of practice. This will mean the evidence requirements and processes to record and review this evidence must be flexible to the diversity of roles and settings of pharmacy practice. However, the core standard will be common across all pharmacy professions.

3. The framework will complement and where possible incorporate existing mechanisms provided by organisations within pharmacy that support continuing fitness to practise assurance.

We will develop the framework in association with partner organisations and pharmacy bodies working to support the highest professional standards. Some of these organisations already provide continuing fitness to practice related activities that complement the framework’s ambitions and we will seek to align with suitable existing services.

4. Any framework would need to be appropriately tested, piloted and evaluated using robust evaluation criteria including impact assessment of intended and unintended consequences.

It will be important that any proposed framework is properly costed taking into account costs to GPhC and the pharmacy sector, including opportunity costs. Testing, piloting and evaluation should be based on robust evaluation criteria which make reference to the generic principles agreed by the Department of Health non-medical revalidation working group, November 2008.
but also take into account the developing evidence base around already implemented revalidation models. Impact assessment must also take into account the full sector of pharmacy and characteristics of the individuals making up the pharmacy professional registers.
Appendix two – Plan for further Council engagement on revalidation for pharmacy professionals

<table>
<thead>
<tr>
<th>Date</th>
<th>Council activity</th>
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<tbody>
<tr>
<td>December 2018 / February 2019</td>
<td>Council performance monitoring report will start to contain information about revalidation processes</td>
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<tr>
<td>November 2018</td>
<td>Council workshop – seeking views on the evaluation approach for revalidation</td>
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<tr>
<td>March 2019</td>
<td>Council will approve 2019/20 plan for further work to support implementation and evaluation of revalidation as part of approving the annual business plan and budget.</td>
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<tr>
<td>2020</td>
<td>Council workshop on short term evaluation findings</td>
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<td></td>
<td>Council workshop on long term evaluation approach</td>
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<tr>
<td>2021-22</td>
<td>Interim (workshop) and final (meeting) reporting from evaluation activities</td>
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Meeting paper

Council Paper on Thursday, 12 July 2018

Public business

Gender pay gap reporting 2017

Purpose
Further to Council’s request, this paper sets out the organisation’s gender pay gap (GPG) as defined by HM Government’s definition, explains the statutory reporting arrangements and the steps being taken to close the GPG. An earlier version of this paper was discussed at the Remuneration Committee held on 18 April 2018.

Recommendations
For Council to note the GPG reporting arrangements and note the steps being taken to close the GPG.

1. Introduction

1.1. All employers with 250 or more employees are now required to publish their gender pay gap data every year under new legislation that came into force in April 2017. The data must be provided for the snapshot date of 31 March 2017. To comply with regulation such employers must provide:

- the mean gender pay gap
- the mean bonus gender pay gap
- proportion of males receiving a bonus
- the proportion of males and females in quartile bands
- the median gender pay gap
- the median bonus gender pay gap
- proportion of females receiving a bonus

1.2. Those employers must publish their gender pay gap data on HM Government’s GPG reporting site and their own public-facing website. They have the option to set out a written statement on their website.
1.3. The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

1.4. The gender pay gap is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. Council will be cognisant of the unlawfulness of paying people unequally because of gender.

1.5. The GPhC supports the fair treatment and reward of all employees irrespective of gender.

1.6. There are likely to be several reasons why organisations employing less than 250 people are not covered by the GPG regulations. The recently published statistics on business size states that only 1% of UK businesses employ more than 250 people\(^1\). Smaller organisation have certain characteristics that would make gender pay gap reporting more challenging, for example, survey data suggests they have greater workforce volatility\(^2\).

1.7. In addition to greater workforce volatility, on average, smaller organisations have a greater GPG than other, larger organisations (see appendix).

2. Legal considerations & recommendation to publish

2.1. The GPhC employs fewer than 250 people. The introduction of GPG reporting regulations led the GPhC to seek a legal view on whether to include its ‘associated workforce’, i.e. associates, partners, council members in the calculations for the GPG report.

2.2. The legal position clarified the interpretation of what is a “relevant employee” under section 83 of the Equality Act 2010, and further, the referral to case law made clear that the GPhC’s associated workforce is not “in a relationship of subordination.” A decision was therefore taken not to include the ‘associated workforce’.

2.3. No other health care professional regulator includes its ‘associated workforce’ in their calculations. This is clear from their published GPG reports and from feedback gained from the HR network across the sector. Thus, the legal advice received by the GPhC appears to support a widely adopted position shared across whole sector.

\(^{1}\) [http://researchbriefings.files.parliament.uk/documents/SN06152/SN06152.pdf](http://researchbriefings.files.parliament.uk/documents/SN06152/SN06152.pdf) last accessed 28/06/18

\(^{2}\) Survey data suggests average turnover for organisations of less than 250 employees is 21.6%, with a median of 19.2%. Overall, an average of 15.5% employees resigned from their job in 2016, according to XpertHR's annual survey of labour turnover. The median (which falls at the exact midpoint in the range of resignation rates and reduces the impact of exceptionally high or low figures in the overall calculation) voluntary resignation rate stood at 13.1%. These figures are not significantly different to those recorded in 2015: an average of 16.1% and a median of 14.1%. [https://www.xperthr.co.uk/survey-analysis/labour-turnover-rates-survey-2017/162496/?keywords=labour%20turnover%20rates%202017](https://www.xperthr.co.uk/survey-analysis/labour-turnover-rates-survey-2017/162496/?keywords=labour%20turnover%20rates%202017) last accessed 28/06/18
2.4. While the GPhC had less than 250 employees on payroll as at 31 March 2017 (there were 225 employees at that point), publication of the organisation’s report as part of an initiative to improve transparency was recommended to the Remuneration Committee in April 2018.

2.5. The Committee agreed with this recommendation. The GPhC’s GPG Report was therefore published on 23 May 2018 on the GPhC’s website³.

3. GPhC GPG report methodology

3.1. Information was collated by using employee salary and working hours data and the average FTE salary by gender was worked out. The next step was to calculate the median pay gap. This was achieved by ranking the FTE salaries of all male and female employees highest to lowest and finding the median value for both genders. The final step was to work out the percentage of males and female in each quartile. This was completed by ranking all employee by their FTE salaries and the splitting them into quartiles.

3.2. Each quartile was then evaluated separately to understand the distribution of males and females. This provided the results for the GPhC gender gap report.

3.3. These calculations were undertaken independently by our partner Expert HR Ltd, and then checked by GPhC finance and payroll professionals. Unlike some others in our sector, the GPhC does not pay bonuses.

3.4. The key aspects of the report can be found in the Appendix.

4. Analysis and benchmarking

4.1. With a mean gender pay gap of 14.2% and a median gender pay gap of 16.5%, both the mean and median gender pay gap outcomes are in favour of men, based on a snapshot of earnings taken on 31 March 2017. The mean and the median are lower however than the national averages and for organisations that are smaller than 250 employees (see appendix).

4.2. For the GPhC, both the mean and the median are not greatly divergent. This suggests that the dataset is not skewed by very low earners (where the mean is far below the median) and/or by a group of very high earners (where the mean is above the median).

4.3. Based on this profile, the CIPD advises that an employer “can be reasonably certain that employees, male and female, are being paid within the same income range”⁴. This

assessment is validated by the difference between male and female earnings in the upper quartile field. This difference is significantly smaller than in the other quartiles reported upon.

4.4. Four regulators in our sector are above the 250-employee reporting threshold\(^5\). Based upon data in the public domain, there is evidence that the GPhC is not an outlier in the healthcare professional regulation sector. For example, the GMC reports a mean GPG of 15.8%.

4.5. The evidence shows however that the GPhC is above the average mean GPG of 10.32% based upon the published information in the sector. Whilst the GPhC is also above median GPG of 9.1%, it is not an outlier as the GDC reports a median of 18.4%.

4.6. Across our sector, the greatest divergence where the mean is far above the median GPG (suggesting the dataset is skewed by very high earners) is at the GMC. And the greatest divergence where the mean is far below the median (suggesting the dataset is skewed by low earners) is at the GDC.

5. **Closing the gender pay gap**

5.1. The GPhC is committed to tackling the gender pay gap and developing an inclusive culture where all employees are treated fairly and feel supported. There are many actions we propose to take to close the gap.

5.2. **Pay and reward review**

By undertaking a systematic review of pay and reward in 2018 and 2019, the GPhC will consider a wide range of rewards and recognition options, both financial and non-financial. There is an aspiration for new pay and reward arrangements to be ready for spring 2019.

5.3. **Publicising consistent pay and reward processes**

As a part of the renewal of GPhC HR policies, forthcoming policies will address several relevant topics. These will include publishing interim guidance on starting salaries and promotion pay. Our policy approach will promote greater fairness through consistent and fair application of revised pay practices. There will be an expectation that reward decisions will be made collaboratively and in line with performance standards.

\(^5\) These are: General Medical Council, Health and Care Professionals Council, Nursing and Midwifery Council, and the General Dental Council
5.4. **Supporting career progression**

The GPhC is also committed to supporting the development of employees and is introducing revised approaches to talent management for all grades. We encourage and support employees to create both short and long-term development and career plans. The new PDR discussions ensure all team members take the time to have regular career conversations. This dedicated focus will support all employees to identify their career aspirations and potential to progress within the GPhC and, possibly, across the wider sector.

5.5. **Attracting diverse talent**

In spring 2018, the GPhC undertook a review of its approach to employee resourcing. Approved by the Senior Leadership Group, the organisation is now developing its recruitment processes to provide a consistent approach for all campaigns and includes actions such as:

- ensuring all roles are available on full time, part time and job share basis apart from in exceptional circumstances
- running an anonymous application process at sift stage
- ensuring all interviews have diverse and, particularly, gender balanced panels; and
- mandating that all panel members complete appropriate recruitment and selection training (including unconscious bias training) within the past 12 months.

5.6. The review of quartiles revealed that most employees in the lower three quartiles are women. We aim to see a greater representation at all levels and will therefore be working to ensure a review of diversity data from recruitment is undertaken to identify trends and identify any further actions that can be taken in attraction, screening, and selection, or in at any part of the recruitment process.

6. **Equality and diversity implications**

6.1. We are also committed to supporting the wider equality, diversity and inclusion agenda through the following activities:

6.2. **Promoting family-friendly policies**

The GPhC supports and encourages flexibility, taking into account the needs of our work and employees. Therefore, the GPhC operates a flexible working policy with a wide
variety of options including home working, job sharing and part-time working to support the work-life balance of our workforce. Alongside this, the GPhC has a growing range of enhanced policies in place to support parents, carers and prospective carers. These policies include reference to support from the HR team cover the run up to the period of leave, the time away and return to work to support all employees the best we can. Renewed HR policies now cover maternity, shared parental leave, paternity, adoption, career break and time off for dependants.

6.3. **Our values and culture**

The Senior Leadership Group and Heads of Function were fully engaged in shaping and identifying the GPhC’s new culture statement and related high impact statements to ensure the organisation has an inclusive culture in which all are valued. The GPhC updated culture statement defines what is important:

“We hold ourselves to the standards we expect of others”

United by our strong sense of doing the right thing for the public and our registrants and by public service, as set out by our new Code of Conduct, we wish to live by our values that run through all that we do. Values based recruitment seeks to emphasise our new approach and, as set out above, we are launching new approaches to employee recruitment in 2018 and 2019.

6.4. **Promoting employee voice**

The GPhC utilises a variety of channels for everyone in the GPhC to have their say and shape our organisation. One of these is the Employee Engagement Forum, which is made up of diverse range of employees from across the GPhC which discusses all new policies and HR practices, offering feedback and inputting the views of employees to the SLG so that a well-rounded view can be formed before making decisions.

6.5. The GPhC also benefits from our EDI Leadership Group which ensures that the organisation maintains an enjoyable, supportive and inclusive environment, where diversity is respected, and everyone feels valued. The diversity and equality networks in the GPhC include those related to LGBT and BAME.

7. **Communications**

7.1. The communication of the GPG report for the GPhC coincided with several other parallel workstreams, including the review of pay and reward, the ‘holding position’ for the June 2018 pay award and the agreement of a new approach to market supplements. Our
communication planning was properly developed and carefully drafted, mindful of both internal and external audience needs.

7.2. For example, our GPG report referred to aspects of our plan above (in less detail) to close the GPhC’s gender pay gap and sought to emphasise the key themes set out above.

8. Resource implications
8.1. There are no dedicated, new resources required.

9. Risk implications
9.1. Treatment of the risks associated with publication of the GPhC’s gender pay gap report included consideration of potential reputational damage. This was balanced with the benefits of disclosing materials that we are not obliged to publicise, to promote transparency. The business case for diversity and inclusion is well known and evidenced. As a leading regulator we take EDI seriously and may have made headway. There is more we can and will be doing and the actions set out above focus on tackling the gender pay gap and our wider approach to diversity and inclusion.

10. Monitoring and review
10.1. We will review and reassess our actions on an annual basis and ensure the Council is advised on progress being made.

Recommendations
For the Council to note the GPG 2017 report.

Gary Sharp, Human Resources
General Pharmaceutical Council

gary.sharp@pharmacyregulation.org

Tel 020 3713 7942

28 June 2018
Appendix 1

Table of definitions:

<table>
<thead>
<tr>
<th>Mean gap</th>
<th>The difference between the mean* hourly rate of men and women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*average pay for all men and average for all women employees</td>
</tr>
<tr>
<td>Median gap</td>
<td>The difference between the median* hourly rate of pay of men and women</td>
</tr>
<tr>
<td></td>
<td>*middle value for all men and middle value for all women employees</td>
</tr>
<tr>
<td>Quartile bands</td>
<td>The proportions of men and women in the lower; lower middle; upper middle; and upper quartile bands</td>
</tr>
</tbody>
</table>

Where % are referred to, 225 are “relevant employees” within the GPhC who were used for GPG reporting statistics.

Gender pay gap data

14.2% GPhC mean gender pay gap
16.5% GPhC median gender pay gap
GPhC pay quartiles percentages (% of relevant employees in each band):

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.8%</td>
<td>71.2%</td>
<td>Includes all employees whose standard hourly rate places them at or below the lower quartile</td>
</tr>
<tr>
<td>26.4%</td>
<td>73.6%</td>
<td>Includes all employees whose standard hourly rate places them above the lower quartile but at or below the median</td>
</tr>
<tr>
<td>32.1%</td>
<td>67.9%</td>
<td>Includes all employees whose standard hourly rate places them above the median but at or below the upper quartile</td>
</tr>
<tr>
<td>54.7%</td>
<td>45.3%</td>
<td>Includes all employees whose standard hourly rate places them above the upper quartile</td>
</tr>
</tbody>
</table>
Benchmarking the GPhC Gender Pay Gap: Mean GPG

This figure is based on:

- A mean male hourly rate of £26.47
- A mean female hourly rate of £22.72

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean gender pay gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Pharmaceutical Council</td>
<td>14.2</td>
</tr>
<tr>
<td>Whole sample (from across all clients who used Expert HR GPG Reporting Service)</td>
<td>16.7</td>
</tr>
<tr>
<td>Sector: Healthcare Professional Regulator</td>
<td>10.3</td>
</tr>
<tr>
<td>Sector: Charities / not for profit</td>
<td>10.5</td>
</tr>
<tr>
<td>Turnover: Under £100 million</td>
<td>15.0</td>
</tr>
<tr>
<td>Employees: 1 – 249</td>
<td>19.2</td>
</tr>
</tbody>
</table>


All employees: 17.4; Human health and social work: 25.0; Other services: 22.1
Benchmarking the GPhC Gender Pay Gap: Median GPG

This figure is based on:

- A median male hourly rate of £24.89
- A median female hourly rate of £20.80

<table>
<thead>
<tr>
<th>Group</th>
<th>Median gender pay gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Pharmaceutical Council</td>
<td>16.5</td>
</tr>
<tr>
<td>Whole sample (from across all clients who used Expert HR GPG Reporting Service)</td>
<td>14.1</td>
</tr>
<tr>
<td>Sector: Healthcare Professional Regulator</td>
<td>9.1</td>
</tr>
<tr>
<td>Sector: Charities / not for profit</td>
<td>7.6</td>
</tr>
<tr>
<td>Industry: Not for profit</td>
<td>7.6</td>
</tr>
<tr>
<td>Turnover: Under £100 million</td>
<td>12.6</td>
</tr>
<tr>
<td>Employees: 1 - 249</td>
<td>17.2</td>
</tr>
<tr>
<td>National Statistics (ASHE 2017)</td>
<td>All employees: 18.4; Human health and social work: 18.8; Other services: 23.6</td>
</tr>
</tbody>
</table>
## Benchmarking the GPhC Gender Pay Gap: Quartiles

<table>
<thead>
<tr>
<th>Group</th>
<th>Lowest paid quartile</th>
<th>Lower middle quartile</th>
<th>Higher middle quartile</th>
<th>Highest paid quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Pharmaceutical Council</td>
<td>Male: 28.8%</td>
<td>Male: 26.4%</td>
<td>Male: 32.1%</td>
<td>Male: 54.7%</td>
</tr>
<tr>
<td></td>
<td>Female: 71.2%</td>
<td>Female: 73.6%</td>
<td>Female: 67.9%</td>
<td>Female: 45.3%</td>
</tr>
<tr>
<td>Whole sample (from across all clients who used Expert HR GPG Reporting Service)</td>
<td>Male: 48.4%</td>
<td>Male: 54.5%</td>
<td>Male: 59.7%</td>
<td>Male: 66.0%</td>
</tr>
<tr>
<td></td>
<td>Female: 51.3%</td>
<td>Female: 45.5%</td>
<td>Female: 40.3%</td>
<td>Female: 34.0%</td>
</tr>
<tr>
<td>Sector: Healthcare Professional Regulator</td>
<td>Male: 32.62%</td>
<td>Male: 34.18%</td>
<td>Male: 36.74%</td>
<td>Male:45.86%</td>
</tr>
<tr>
<td></td>
<td>Female:67.38%</td>
<td>Female: 65.82%</td>
<td>Female: 63.36%</td>
<td>Female: 54.14%</td>
</tr>
<tr>
<td>Sector: Charities / not for profit</td>
<td>Male: 30.8%</td>
<td>Male: 32.5%</td>
<td>Male: 33.8%</td>
<td>Male: 41.6%</td>
</tr>
<tr>
<td></td>
<td>Female: 67.4%</td>
<td>Female: 67.5%</td>
<td>Female: 66.2%</td>
<td>Female: 58.4%</td>
</tr>
<tr>
<td>Industry: Not for profit</td>
<td>Male: 30.8%</td>
<td>Male: 32.5%</td>
<td>Male: 33.8%</td>
<td>Male: 41.6%</td>
</tr>
<tr>
<td></td>
<td>Female: 67.4%</td>
<td>Female: 67.5%</td>
<td>Female: 66.2%</td>
<td>Female: 58.4%</td>
</tr>
<tr>
<td>Turnover: Under £100 million</td>
<td>Male: 48.0%</td>
<td>Male: 52.9%</td>
<td>Male: 58.3%</td>
<td>Male: 63.8%</td>
</tr>
<tr>
<td></td>
<td>Female: 52.0%</td>
<td>Female: 47.1%</td>
<td>Female: 41.7%</td>
<td>Female: 36.2%</td>
</tr>
<tr>
<td>Employees: 1 - 249</td>
<td>Male: 49.1%</td>
<td>Male: 55.4%</td>
<td>Male: 62.8%</td>
<td>Male: 68.7%</td>
</tr>
<tr>
<td></td>
<td>Female: 48.6%</td>
<td>Female: 44.6%</td>
<td>Female: 37.2%</td>
<td>Female: 31.3%</td>
</tr>
</tbody>
</table>
Meeting paper

Council meeting on Thursday, 12 July 2018

Public Business

Council member appointments 2019

Purpose
To consider recommendations on the process for filling Council member vacancies arising in March 2019

Recommendations
The council is asked to:

I. agree that the five Council member vacancies arising in March 2019 will be filled using an open competition process;
II. agree the updated selection criteria and competencies for new Council member appointments at Appendix 1; and,
III. note the next steps in the appointments process and timetable.

1. Introduction
1.1. On 31 March 2019, five Council members will complete their terms of office. None are eligible for reappointment meaning that the vacancies will need to be filled using an open competition process.
1.2. The recruitment campaigns will be open to both registrant and lay applicants. In order to keep the balance of Council, as required by statute, the appointments process will recruit two lay members and three registrant members.
1.3. Our role is to assist the Privy Council to make the appointments. The appointments process will be carried out in accordance with the Professional Standards Authority’s (PSA) ‘Good Practice in Making Council Appointments’ guidance and the principles of merit, fairness, transparency and openness and inspiring confidence. The Council is responsible for ensuring that the appointments process is undertaken appropriately and in a timely manner, and for allocating sufficient resources to it.
1.4. This paper is the first step in the appointments process for 2019. It provides an overview of the proposed recruitment process; outlines proposals to secure an executive search agency to manage the process; confirms membership of the appointment selection panel; and, recommends revisions to the selection criteria and competencies.

2. Key considerations

(a) The recruitment process

2.1. In a change to previous recruitment exercises, the 2017 process was managed in-house without external recruitment consultancy support. The Governance team took on the roles previously provided by the recruitment consultants, including managing the advertising; undertaking the initial sift of all candidates; arranging for preliminary interviews to be carried out by the contracted senior HR support following panel longlisting; and, making arrangements to support the panel in shortlisting and final interviews.

2.2. For the 2019 process, we propose to use the services of an executive search agency to manage the process in order to secure the experience and expertise required for non-executive appointments. Whilst the 2016/17 process was successful and met the scrutiny requirements of the PSA and Privy Council, we want to go further to increase the diversity of potential applicants and see a progressive shift in Council composition. One way of doing this is to use the services of an executive search agency, with particular expertise in attracting diverse and experienced talent pools externally.

2.3. Additionally, in 2017/16, we received 279 applications in total (144 registrant and 135 lay). The process change placed a considerable burden on the Governance team in resource terms, which included assessing each application against the initial sift criteria and guidance, and redacting information that could identify candidates.

(b) Selection criteria and competencies

2.4. The selection criteria and competencies used to select Council members should reflect the current and expected future needs of the Council. In line with PSA guidance, it is good practice to review these regularly, especially if regulators need to fill a number of vacancies. The criteria must not directly or indirectly discriminate against, or deter applications from, any particular group.

2.5. Prior to the 2017 round, the criteria were reviewed by the Council working group to make them more accessible and these were updated accordingly. In 2017, Council agreed that they could continue to be used and that there was no obvious skills deficiency on Council. As such, there would be no desirable criteria.

2.6. For the 2019 round, we have reviewed, with the Chair, the skills mix of the current Council cohort and identified a number of gaps in knowledge and expertise. In order to address these gaps, we are proposing to include the following desirable criteria:
• significant NHS management or leadership experience (registrant members)
• experience of working as a pharmacy technician
• experience of technology developments in healthcare (registrant and lay members)
• patient or carer experience (lay members)
• experience of pharmacy education development or delivery (registrant members)

2.7. The updated criteria can be found at Appendix 1. Council should note that we are not recommending changes to the essential criteria or core competencies.

(c) The selection panel

2.8. The role of the selection panel is to assess candidates against the published criteria, in accordance with the published process, and decide which candidates to recommend for appointment.

2.9. In accordance with the PSA’s guidance, selection panels should consist of at least three and no more than five members and should be credible to inspire confidence in the integrity of the process. Panels must also include at least one member, who is independent of the regulator in order to bring an impartial perspective.

2.10. For 2019, we propose to reconstitute the panel from the previous appointment process (a total of four panel members including the independent panel member and the Chair of Council). In line with PSA guidance, it is normally appropriate for the Chair to sit on selection panels. Initial enquiries have been made and the panel members are available to take part in the process.

(d) Time commitment and remuneration

2.11. No changes are proposed to the existing time commitment and remuneration packages for the Council member roles.

(e) Timetable and next steps

2.12. Based on the 2017 open competition process, the estimated timeline for the campaign would be approximately seven months (from initial advertisement in September 2018 to taking office in April 2019). This timetable includes the required stages of the PSA scrutiny process and the Privy Council approval process, with the confirmation of Council appointments expected in March 2019.

2.13. Subject to Council’s approval of the proposed approach, we will update the PSA and the Privy Council about our plans and the timetable for this work. We intend to submit the initial ‘Advance Notice of intent to recommend appointment’ to the PSA in August as this needs to be completed at least three weeks before the advertising deadline. We have
already notified the PSA of the numbers of upcoming vacancies and when these need to be filled.

3. Equality and diversity implications

3.1. In designing the recruitment process and selection criteria and competencies for the 2019 appointments, we must consider how to attract a broad, diverse range of suitably qualified candidates, as well as the wider need to conduct the recruitment and selection processes in line with good practice in relation to equality and diversity.

3.2. Our equality and diversity strategy will include (but is not limited to) the following key elements:

- An equality impact assessment, setting out how we have had due regard for our equality obligations through the planning and implementation of the appointments process
- Using an external agency to avoid any direct, associative, perceptive or indirect discrimination – and to increase the diversity of the candidate talent pool
- Designing our advertising campaign to ensure broad appeal and to identify a more diverse field
- An accessible application form (available in different formats on request) including comprehensive guidance for all applicants
- Offering reasonable adjustments to meet the needs of individual candidates and reminding candidates about this at different points in the process
- Ensuring the selection criteria and competencies have been reviewed and where appropriate changes identified from previous processes, to allow more accessibility and ‘widen the net’ to attract more applicants
- Redacting application forms to ensure that the names of candidates or other information by which they may be identifiable is not included
- Ensuring the selection and decision-making processes are objective, fair and unbiased with robust independent quality assurance established
- Using diversity focussed jobs board to source candidates from traditionally under-represented groups.
- Ensuring the selection panel have an understanding and commitment to equality, diversity and inclusion
- Ensuring panel members have had unconscious bias training
- Keeping equality and diversity monitoring data separate from the main application forms and ensuring that these are not used in the selection process
- Reviewing our equality and diversity monitoring data form to ensure that this remains appropriate and in line with legal and good practice requirements
- Declaring and recording where a candidate is known by a member of the panel (in a professional and/or personal sense)
4. Communications

4.1. The PSA requires vacancies to be advertised for at least four weeks, to give potential candidates sufficient opportunity to see the advertisement and apply. The advertising strategy and communications campaign for the recruitment process will be designed to attract a strong and diverse field of suitable candidates. We have also reviewed the 2017 campaign, alongside the equality and diversity monitoring data, to identify where further steps could be taken to increase the diversity of applicants.

5. Resource implications

5.1. It is anticipated that the recruitment and selection process, including the services of an executive search agency, will be carried out within existing budgets.

6. Risk implications

6.1. An appropriate and robust process for recruiting and selecting Council members is an essential step in ensuring good governance within the GPhC.

6.2. It is essential that our procedures meet the requirements of the PSA’s Section 25c scrutiny process. Failure to ensure that our appointment process meets the four principles of merit, fairness, transparency and openness, and inspiring confidence in regulation means that the PSA may not have confidence in our process. This would result in the Privy Council not making the appointments we recommend.

7. Monitoring and review

7.1. Council will be kept updated and informed on the appointments process as this moves forward.

Recommendations
The council is asked to:

I. agree that the five Council member vacancies arising in March 2019 will be filled using an open competition process;
II. agree the updated selection criteria and competencies for new Council member appointments at Appendix 1; and,
III. note the next steps in the appointments process and timetable.
Laura McClintock, Chief of Staff
General Pharmaceutical Council
laura.mcclintock@pharmacyregulation.org
Tel 020 3713 8079

3 July 2018
Revised selection criteria and competencies

**Essential criteria**

**Essential criteria - all applicants must demonstrate the following:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E1</strong> Working within a framework</td>
<td>An appreciation of and commitment to protecting, promoting and maintaining the health, safety and wellbeing of patients and the public.</td>
</tr>
<tr>
<td><strong>E2</strong> Analytical and decision making skills</td>
<td>The ability to identify problems, options and solutions, considering risks, consequences and impact. Ability for forward thinking and to see the bigger picture.</td>
</tr>
<tr>
<td><strong>E3</strong> Collaborative and professional communication skills</td>
<td>The ability to work with others, to challenge, listen and question constructively. Understanding of alternative perspectives and ability to influence in the pursuit of quality and performance.</td>
</tr>
<tr>
<td><strong>E4</strong> Integrity and respect</td>
<td>Gains trust of others, principled and values based actions. An understanding of and commitment to good governance and to the Nolan principles of public life.</td>
</tr>
</tbody>
</table>

**Additional essential criteria – Registrant applicants only**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E5</strong> Pharmacy professional practice</td>
<td>Up to date knowledge and understanding of the practice of pharmacists and/or pharmacy technicians and an awareness of the factors that influence it.</td>
</tr>
</tbody>
</table>

Note: on this occasion there are no desirable criteria against which the applicants are assessed.

**Desirable criteria**

On this occasion, the Council is particularly seeking candidates with the following skills and experiences:

**D1** – significant NHS management or leadership experience (REGISTRANT MEMBERS)

**D2** – experience of working as a pharmacy technician

**D3** – experience of technology developments in healthcare (REGISTANT AND LAY MEMBERS)

**D4** – patient or carer experience (LAY MEMBERS)
D5 – experience of pharmacy education development or delivery (REGISTRANT)

Competencies for Council members:

<table>
<thead>
<tr>
<th>Competence</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| **C1 Personal qualities**           | - Willing to accept and uphold own accountability and also willing and able to hold others to account for performance of delegated responsibilities  
- A high level of probity, integrity, objectivity and fairness  
- Commitment to equality, diversity and inclusion  
- The ability to maintain confidentiality  
- High level of motivation and a willingness to constantly review and improve performance  
- The ability to display credibility across and beyond the registered pharmacy professions. |
| **C2 Intellectual flexibility**     | - Thinks clearly and creatively  
- Able to analyse complex information – considering the bigger picture as well as the detail – and arrive at sound judgements  
- Able to understand who the GPhC’s key interest groups are and their drivers and priorities  
- Willing to modify thinking in light of new information and dialogue. |
| **C3 Effective influencing and communication** | - Can influence and persuade others using evidence and well-reasoned arguments  
- Capacity to give and take advice  
- Able to test and probe constructively and effectively to achieve the best outcomes for the GPhC and its statutory functions. |
| **C4 Effective team working**       | - Builds constructive relationships and works effectively in a team  
- Understands and maintains the separation between the non-executive and executive function  
- Promotes and supports the corporate decisions of Council  
- Actively seeks the differing views of others and respects those views. |