Council meeting

8 November 2018

11.40 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 11 October 2018*	Nigel Clarke
4.	**Actions and matters arising**	Nigel Clarke
5.	**Workshop summary – 11 October 2018**	Nigel Clarke
6.	**Performance monitoring and annual plan progress report** *For noting*	*18.11.C.01* Duncan Rudkin
7.	**Report on the feedback from the consultation on developing our approach to regulating registered pharmacies** *For noting*	*18.11.08.C.02* Claire Bryce-Smith
8.	**Strategic plan 2017-20 – year three** *For approval*	*18.11.C.03* Duncan Rudkin
9.	**Initial education and training for pharmacists - standards and consultation document** *For approval*	*18.11.08.C.04* Mark Voce
10.	**Revalidation - 2019-20 submissions and standards for pharmacy professionals** *For approval*	*18.11.08.C.05* Osama Ammar
11.	**Review of policies and procedures** *For approval*	*18.11.08.C.06* Laura McClintock
12.	**Registration Assessment and Board of Assessors' report – June and September 2018** *For noting*	*18.11.08.C.07* Damian Day Andrew Husband

13.	**Remuneration Committee minutes (unconfirmed)** *Public session on 27 September 2018* *For noting*	*18.11.08.C.08* Laura McClintock
14.	**Council member remuneration** *For approval*	*18.11.08.C.09* Laura McClintock
15.	**Audit and Risk Committee minutes (unconfirmed)** *Public session on 23 October 2018* *For noting*	*18.11.08.C.10* Digby Emson
16.	**Any other public business**	Nigel Clarke

Confidential business

17.	**Declarations of interest** *Confidential items*	All
18.	**Minutes of the last meeting** *Confidential session on 11 October 2018*	18.11.C.11 Nigel Clarke
19.	**Confidential actions and matters arising**	Nigel Clarke
20.	**Audit and Risk Committee minutes (unconfirmed)** *Confidential session on 23 October 2018* *For noting*	*18.11.C.12* Digby Emson
21.	**Remuneration Committee minutes (unconfirmed)** *Confidential session on 27 September 2018* *For noting*	*18.11.C.13* Berwyn Owen
22.	**Any other confidential business**	Nigel Clarke

Date of next meeting

Thursday, 06 December 2018

Minutes of the Council meeting held on Thursday 11 October 2018 at 25 Canada Square, London at 13:30

TO BE CONFIRMED 8 NOVEMBER 2018

Minutes of the public session

Present

Nigel Clarke (Chair)
Digby Emson
Mary Elford
Mark Hammond
Mohammed Hussain
Jo Kember
Alan Kershaw
Elizabeth Mailey
Evelyn McPhail
Arun Midha
Berwyn Owen – until item 64.
David Prince
Samantha Quaye
Jayne Salt

Apologies

None

In attendance

Duncan Rudkin (Chief Executive and Registrar)
Claire Bryce-Smith (Director of Insight, Intelligence and Inspection)
Matthew Hayday (Interim Director of Fitness to Practise)
Francesca Okosi (Director of People)
Laura McClintock (Chief of Staff)
Helen Dalrymple (Council Secretary)
Tarun Chotai (Interim Head of Finance)
Elisabeth Davies (Chair of the Appointments Committee)
Elaine Mulingani (Associates and Partners Manager)
Rachael Oliver (Head of Communications)

57. Attendance and introductory remarks

57.1. The Chair welcomed all present to the meeting.

58. Declarations of interest

58.1. Council agreed that members would make any declarations of interest before each item.

59. Minutes of the last meeting

59.1. Council wished to also include at minute 44.2. the appointment of the GPhC Pharmacy Technician Clinical Fellow.

59.2. **The minutes of the public session held on the 13 September 2018 were confirmed as a fair and accurate record.**

60. Workshop summary – 13 September 2018

60.1. Council noted that the review of the workshops would be presented at the December meeting. One member noted that a three-month forward plan had been circulated, but suggested it would be helpful for members to have sight of an annual programme, into which would be threaded the development of the organisation's strategy. This would be particularly helpful for new members who would be starting in April 2019.

ACTION: LM

60.2. **Council noted the discussions from the workshop.**

61. Actions and matters arising

61.1. Claire Bryce-Smith (CBS) said that she would like to volunteer an action from the last meeting's minutes at 49.12. In discussion around inspections in the performance monitoring report, Council had queried standard 4.3 on medicines and medical devices. They had asked if would be possible to break it down into more specific areas to provide more granularity on why the standard was not met. A paper would be developed on this for a future discussion, timing to be agreed with the Chair.

ACTION: CBS

61.2. All other actions were in hand or due to be covered at this meeting.

62. Appointments Committee report

62.1. Elisabeth Davies (ED), Chair of the Appointments Committee, presented **18.10.C.01.** This paper informed the Council of the committee's work over the past year.

62.2. Members were taken through the report, which identified five workstreams and provided information on the Appointments Committee's process, their outcomes for 2017/18 and their plans for 2018/19.

62.3. ED thanked Matthew Hayday (MH) and Francesca Okosi (FO) for their leadership and engagement. The change of Chair had meant different ways of working had been introduced which had created more work and their support had been invaluable.

62.4. Council asked whether there were plans to mentor panellists for the upcoming chair vacancies. Succession planning was underway for lay chairs and this would be considered as part of that.

62.5. Members also asked about the lack of black chairs in the panels. ED said that learning had been taken from 2017/18 and would be fed into the next recruitment process. Data showed that their absence was more about encouraging applicants than there being an inherent bias in the process. A lot had been done, but with disappointing returns. This was also true of other healthcare regulators.

62.6. It was suggested that perhaps the recruitment process itself was off-putting. There was a risk that competency-based interviews could principally be a test of interview technique, favouring those who had worked in particular types of organisational environment. ED agreed that the aim should be to create an environment where candidates were enabled to provide the relevant evidence and information about their suitability for the role. ED told members that the Committee had in fact received good feedback about the process from unsuccessful candidates. A balance had to be struck in ensuring that successful candidates had the skills required for a hearing, including being able to contribute fully to group decisions and read large amounts of material.

62.7. Members asked whether the Appointments Committee had all received unconscious bias training and were informed that most had and all would have had it by next year. After further discussion Council said that in future they would be interested to see a more detailed report on who had received what training.

62.8. There was some discussion around the definitions of ethnicity and it was noted that Office for National Statistics census terms were used.

62.9. Council asked whether there was any retention data, ED replied that there were not very many leavers – some went to other positions or retired as they had served their second term of service.

62.10. A member suggested that encouraging younger applicants may solve some issues of diversity as they tended to be closer to, and in registrants' cases, more representative. Elaine Mulingani (EM) said that pharmacy technician applicants tended to be younger but more could be done around this. Applications were competency based and did not demand years of experience.

62.11. Members discussed whether positive action should be employed and ED said that they had been reflecting on this and had agreed to come back to considering it at some point.

62.12. Council discussed the broader question of the quality of feedback. They said that there were mental health pressures on registrants in the fitness to practise process as well on their families and employers. MH said that all who passed through the process were now given the opportunity to provide feedback to try and understand the impact that it had on mental health. Typically, feedback was received from extremes of experience, and a broader view was needed to develop a complete picture. There was also currently a gap in the understanding of families and employers' experiences.

62.13. **Council noted the report.**

63. Fees Rules consultation 2018

63.1. Duncan Rudkin (DR) presented **18.10.C.02**, which provided the Council with the proposed consultation on the Fees Rules to take effect from 1 July 2019.

63.2. Declarations of interest were received from Digby Emson, Mohammed Hussain, Jo Kember, Elizabeth Mailey, Evelyn McPhail, Berwyn Owen and Samantha Quaye as they were all registrants.

63.3. The Chair explained to members that they would be asked to approve the proposed fees as outlined in the cover paper. The consultation itself would be worked on with some members of Council in the immediate week and would come to all members for approval. General points on the consultation, in terms of its tone and structure, were invited.

63.4. Members said that the challenge of estimating the size of the Register, and therefore income, should be acknowledged. The consultation document should include a narrative setting out the work that was underway looking strategically at fees, reserves and savings.

63.5. The document should also indicate the time lag before the financial impact of any rise in fees would be felt by the organisation, in order to explain why it was necessary to run the consultation now.

63.6. Council said that in the past they had indicated a desire to review the levels and structure of fees, mindful of the impact of increases on more vulnerable groups. DR agreed and said that this was very important. It would not be appropriate for this round but would

certainly be part of future work on fees. Council were clear that this must be prioritised next time any changes to fees were considered.

63.7. All agreed that it was likely that the structure of the profession was likely to change in the next few years; online pharmacies, numbers of registrants, the impact of revalidation and higher numbers of people taking breaks from the Register meant that it was likely that the levels and structure of fees would need to be more complex in the coming years. The Chair highlighted that the proposed premises fee was higher than the pharmacist registration fee which in itself marked the beginning of a structural change.

63.8. The new draft of the consultation and timetable would be circulated as soon as possible once the fees had been agreed. Positive agreement from the majority of Council members was needed before the consultation would be launched.

63.9. **Council agreed to consult on proposals to increase the entry and yearly renewal fees for**

- **pharmacists by £7 from £250 to £257**
- **pharmacy technicians by £3 from £118 to £121**
- **pharmacy premises by £21 from £241 to £262.**

64. Engagement and communications report

64.1. Rachael Oliver (RO) presented **18.10.C.03**, which kept Council abreast of engagement and communications with stakeholders via a quarterly report.

64.2. RO confirmed that meetings with Jeane Freeman, Cabinet Secretary for Health in Scotland and the sessions at the Pharmacy Show had gone ahead successfully.

64.3. Responses to the letter referred to at 3.3 of the paper, from the Chief Executive to organisations representing community pharmacy owners would be collated and published at a later date.

64.4. Members asked for an update on the patient representatives working with the Education team. RO said that two had been appointed to the Education Advisory Group who were advising the development of the education programme. They had their first meeting earlier that week and had made a positive contribution.

64.5. Council highlighted para 5.2 where the paper reported that since the introduction of online pharmacist applications the number of applications that were incomplete and needed further work had dropped from around 50% to between 13-16% of total applications. This was significant progress and should be applauded.

64.6. Members wished to record their appreciation and thanks to the inspectors who had presented at various local pharmacy meetings listed in the paper. Those members who had attended the meeting were struck by their professionalism and intelligence.

64.7. There was some discussion around support for inspectors at these meetings if they were on their own. CBS assured members that investment had been made in making sure that they were well prepared and that they had training on presentation and communication skills. If it was known that a meeting was going to have a large turnout then more than one inspector would attend.

64.8. Some members said that they would like to attend meetings with the Chair and Ministers; though it was acknowledged out that these meetings were at the invitation of the Minister and that it may not be appropriate to bring anyone else.

64.9. The Chair extended his thanks to the Scottish Directors of Pharmacy who he had met with to hear their views and engage with them on the work on the initial education and training of pharmacists.

64.10. **Council noted the paper.**

65. Professional Standards Authority (PSA) annual performance review

65.1. Laura McClintock (LM) presented **18.10.C.04.** This paper updated the Council on the Professional Standards Authority (PSA) performance review process for 2017/18.

65.2. DR highlighted 2.4 where the PSA had referred to the organisation's work on the safe and effective pharmacy team guidance and workplace pressures. When developing their new Standards of Good Regulation they may in future be more explicit about reporting on our work with registered pharmacy premises, which is not currently within the scope of the performance review.

65.3. The Chair congratulated the team on meeting the all the PSA standards for the third year running and on the constructive development of their relationship with the PSA.

65.4. **The Council noted the outcome of the 2017/18 performance review.**

66. Any other business

66.1. Council expressed their thanks to Elaine Mulingani as this was her last Council meeting. They thanked her for an extraordinarily well-done job and for being a force for ensuring the best possible processes were in place. She had also managed the transition in chairs of the Appointments Committee with aplomb.

66.2. It was also Helen Dalrymple's last Council meeting. Members thanked her for her excellent work and support over the last few years.

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

Date of the next meeting:

Thursday 8 November 2018

Meeting paper

Council on Thursday, 08 November 2018

Public business

Council Workshop Summary

Purpose

To provide an outline note of the discussions at the Council workshop in October.

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 October workshop

2.1. ***Governance and regulation of post-registration education and training***

Council members were updated on the work to set up an Education Governance and Oversight Board (EGOB), which is being hosted by the Royal Pharmaceutical Society. The GPhC, along with a number of other organisations and groups, were invited to attend the

initial meeting on 27 September 2018. The Council discussed the proposed work of the group in the context of any links or connections with our own work to develop our long-term vision and strategy, as well as the role for the GPhC going forward.

2.2. ***Registered pharmacies – consultation headlines and next steps***

Council members were given an overview of the key findings from our consultation on developing our approach to registered pharmacies. This included a summary of the primary policy areas explored through the consultation as well as a recap on the engagement and consultation work carried out across the three countries. Members were informed that the formal report of the consultation will be presented at the Council meeting in November, with a view to formal policy recommendations being brought for decision in December. Members were also reminded about our new enforcement powers and had the opportunity to ask questions and explore how these might be used in the future.

2.3. ***Engaging on our 10 year vision***

Members discussed outline proposals for engagement on our 10 year vision and strategy. This included a draft timetable, incorporating a range of engagement options from informal discussions through to a roundtable with key stakeholders. Council members were also invited to discuss how they might be involved in the engagement process.

Recommendations

Council is asked to note the discussions from the workshop

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29 October 2018

Council actions log

Meeting date	Ref.	Action	Owner	Due date	Status	Comments/update
13 September 2018	52.3.	Revised draft standards combining a time and competency approach to independent prescribing programmes would be brought to Council, as well as further analysis of the feedback to the consultation by sector.	MV	Dec 18	Open	
11 October 2018	61.1.	CB-S to report back to Council on granularity of reporting on standards met and not-met (eg. standard 4.3) in the wider context of our work on analysis and reporting across a range of fronts. Timing to be agreed with the Chair	CB-S	tbc	Open	

Meeting paper

Council on Thursday, 08 November 2018

Public business

Performance Monitoring and Annual Plan Progress Report

Purpose

To report to Council on operational and financial performance and progress against the annual plan from July to September 2018.

Recommendations

The Council is asked to note and comment on:

i. the performance information provided at appendix 1; and

ii. the report on progress against the 2018/19 annual plan at appendix 2.

1. Introduction

1.1. This paper reports on operational and financial performance and progress against the annual plan, as part of our business report. This report provides an overview of quarter 2 covering July to September 2018.

1.2. Prior to submission to Council, the content of these reports is now reviewed by the Senior Leadership Group (SLG) operating as a Performance and Delivery Board with a focus on monitoring the operational performance of the organisation and delivery against agreed plans.

1.3. This allows a more pro-active and collective approach to be taken to emerging issues and supports a closer link to be made between delivering our regulatory responsibilities and dealing with operational challenges whilst continuing to deliver on strategic priorities. It also provides an opportunity to acknowledge where good progress is being made.

1.4. The section below provides an executive summary of key areas to note.

2. Performance Monitoring Report

2.1. Appendix 1 reports on the operational and financial performance of the organisation. It is the second progress report to Council this year.

2.2. Some key areas to note in the reporting this quarter include:

- The impact on the Customer Contact Centre (CCC) with the continued release of online functionality, implementation of new revalidation requirements and registration of successful candidates following the June assessment.
- The decrease in fitness to practise concerns received and a focus on getting through the immediate caseload with reduced capacity.
- A slight reduction in the number of routine inspections over this period and the increase in the number of pharmacies not inspected for 36 months or more.
- Standard 2.1, which relates to the adequacy of staffing which we have been monitoring, has appeared in the top 5 standards not met for the third time but has moved down the rankings to joint fifth.
- The stability rate has decreased slightly since the last quarter.
- In our drive to improve data quality and as part of our development to automate the report, we have updated our calculations and units of measurements from months to weeks where applicable to increase the value in trend reporting for more consistent time periods. This also aligns with the units of measurements for reporting in the Professional Standards Authority dataset making these more comparable. No changes have been made to data reported in previous quarters unless it is a correction.

2.3. The following paragraphs provide some further narrative around the sub-points above.

2.4. New registration activity is the busiest period of normal business for the CCC in this quarter providing support for: registering pre-registration training, registering new Pharmacists following the June assessment, registration assessment candidates for the September sitting and queries related to the renewal deadline of 31 October 2018 for the main cohort. Record volumes of both calls and emails have been handled by the CCC with highest totals ever reported for one quarter.

2.5. The number of concerns received has dropped for the first time in three quarters. The average number of concerns per month is now 220, down from 230 for this fiscal year. In comparison to Q2 2017/18 a year ago, the total number of cases triaged has increased by 72 (12.8%). Our total number of cases being worked on at any one time has also increased but only by 29 (4%) since the last quarter. There have been a number of staff movements this quarter which has resulted in a slight drop in productivity as capacity reduces to cover any vacancies.

2.6. The number of routine inspections over the period decreased from 961 to 940. This is due to several factors including increased planned annual leave due to seasonal holiday periods *during* this quarter, the delivery of local presentations for the registered pharmacies consultation which closed in August, and a three-day inspection training event in September. It is also noted that the number of follow up visits increased from 48 to 64 in this quarter and there was also a small increase in the number of visits before registration. The number of months since the previous inspection has increased for those over 36 months. We have been monitoring standard 2.1 which relates to the adequacy of staffing, this has appeared in the top five standards not met for the third consecutive quarter, however, this has dropped to joint fifth place representing around 3% of pharmacies inspected.

2.7. With regard to headcount, the stability rate (based on the number of permanent employees with more than 12 months employment at the GPhC) has decreased from the previous quarter (April to June 2018) from 85% to 79%. The stability rate fluctuates between quarters going down and up which we are continuing to monitor.

2.8. The year to date position for the organisation overall is a variance of £362K against the revised budget including interest and tax. Work is continuing on our financial strategy which includes a number of workstreams. The reforecast process is currently underway and a first draft estimate of our forecast to the end of the financial year is currently being re-reviewed for accuracy and consistency.

2.9. Calculations for 24 measures in Tables 2.1, 2.2, 2.4, 3.2, 3.3 have been updated to move to reporting in weeks for age brackets. The impact on the data for this quarter is minimal where slightly higher numbers in some age groups are now showing compared to the grouping in months previously.

3. Annual plan progress report

3.1. Appendix 2 reports on progress against the Annual Plan 2018/19. This is the second progress report to Council this year. Whilst activities may have progressed since quarter 2, reporting remains focused on this period as part of good governance and so that this aligns with reporting mechanisms and timescales elsewhere.

3.2. The content of this report sets out progress made against our strategic priorities. It also reflects our work in taking a longer-term view of our priorities, planning and resources as we look at our vision and strategy moving forwards.

3.3. The RAG status of each of the strategic priorities is reviewed and collectively agreed by the Senior Leadership Group, when operating in a Performance and Delivery Board mode.

3.4. Status of work in this quarter is as follows:

Strategic Priorities	**Status**	**Direction of travel**
Building our data, information, intelligence and insight capability	A	↓
Developing our approach to fitness to practise	R	↓
Securing assurance and promoting improvement in registered pharmacies	G	→
Improving standards of care through regulation of education and training	G	↑
Transforming our organisation, our services and processes	A	→

3.5. The following paragraphs provide further explanation on the RAG statuses above.

3.6. Building our data, information, intelligence and insight capability – this status has changed from green in the previous quarter, to amber in quarter 2. This is due to delays in completing scheduled GDPR activities this quarter because of the volume and nature of information requests received and being managed. Nevertheless, there has been good delivery against other activities outlined in the timetable.

3.7. Developing our approach to fitness to practise – the status for this strategic priority has changed from amber in the previous quarter to red in quarter 2 and reflects the current position of the strategy development. Anticipating the arrival of a new director, the strategy work in the immediate future will now focus on planning how best to test the approach to handling concerns with a wider set of stakeholders and refine it as a result of those discussions. Research on changes to fitness to practise in the health professions sector will continue as well. This work, and that of developing the approach to consultation has been reprioritised due to the volume of concerns received and turnover within the directorate.

3.8. Securing assurance and promoting improvement in registered pharmacies – this status has remained the same (green) since the previous quarter. This reflects the good progress made against the actions planned for this quarter, the majority of which cover the continuation of work already underway.

3.9. Improving standards of care through regulation of education and training – this status has moved from amber in the previous quarter to green in quarter 2. Whilst the complexity, nature and volume of work remains high, the green rating reflects the good progress being made.

3.10. Transforming our organisation, our services and processes – this status remains amber from the previous quarter reflecting the stage we are at with some of our areas of work. There are a number of outstanding governance and management issues including action points from cost metrics and transformation audits which are not yet complete and are contingent on the progress of our long-term vision and strategy work.

3.11. In our reporting, we continue to look to provide transparency on how we have progressed against the timetable we set ourselves for the annual plan year; where we have proceeded in accordance with the timetable; those areas where we have fallen behind or where we might be ahead of where we thought we would be. We are continuing to ensure closer links between the content of the annual plan progress report and the performance monitoring report to reflect the fact that we need to continue to meet our regulatory responsibilities and deal with operational challenges, whilst still looking to deliver against our strategic priorities. Further explanation with regards to the timetable is provided in the commentary.

3.12. Last quarter we said that the inclusion of success measures for the annual plan this year represented progress in this area and an indication of intent moving forwards. We also recognised that this is not just about management process but a wider change in culture as well, with everyone knowing what success looks like. Work on this theme continues as we look to develop it as part of all the work that we do.

4. Equality and diversity implications

4.1. Our aim is to embed equality, diversity and inclusion in both our role as a regulator and an employer. We will continue to look at how we can monitor and demonstrate our progress towards this aim.

5. Communications

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

5.2. Internal communications on our annual plan including the detail that sits underneath will be important as we go through a period of change. There have been transparent and specific communications around key stages of activities within the plan to inform and engage with staff, including relevant content on the staff intranet.

6. Resource implications

6.1. Resource implications are addressed within the report.

6.2. The allocation of resources required to progress with the annual plan as well as normal operational delivery has been a key consideration in developing our budget and fee setting proposals.

7. Risk implications

7.1. The strategic risk register will continue to be reviewed as part of our management framework and risks will be recorded and reviewed in relation to our work.

7.2. Main risks associated with the delivery of the annual plan are included as part of the annual plan progress report.

7.3. With regards to operational performance, failure to maintain an accurate register and/or carry out our other regulatory functions efficiently and effectively could have implications on patient safety, and a significant impact on the GPhC's reputation.

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

8. Monitoring and review

8.1. Council will receive a performance monitoring and annual plan progress report on a quarterly basis, providing an update on the delivery of the GPhC's regulatory functions and progress against the annual plan.

8.2. As highlighted earlier in the paper, the Senior Leadership Group now convenes as a Performance and Delivery Board reviewing the content of both the performance monitoring report and annual plan progress report, on a quarterly basis prior to Council.

8.3 We continue to be mindful of and look to feed in learning from planning and reporting previously as part of our commitment to continuous learning and improvement.

Recommendations

The Council is asked to note and comment on:

i. the performance information provided at appendix 1; and

ii. the report on progress against the annual plan at appendix 2

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Performance Monitoring Report: end September 2018

1. Customer services

1.1 Registrations

	Route to Register	2017/18			2018/19	
		Q2	Q3	Q4	Q1	Q2
Pharmacists	Total	2,321	597	243	86	2,334
	UK	2,260	561	200	56	2,257
	EEA	20	22	31	24	29
	Non-EU/EEA	41	14	12	4	48
	Need clarification				1	
Pharmacy technicians	Total	350	441	211	207	336
	UK	343	438	209	207	333
	EEA	5	2	2		3
	Non-EU/EEA	2	1			
Registered pharmacies		102	79	82	73	81

Includes new joiners and restorations up to 30th September 2018

Following the summer registration assessment new pharmacist entrants were in line with historic figures for this quarter last year based upon the pass mark.

1.2 Registration Totals

	Total	Budgeted	Variance
Pharmacists	57,098	57,062	36
Pharmacy technicians	23,493	23,551	-58
Registered pharmacies	14,325	14349	-24

Register totals as at 30th September 2018

1.3 Median application processing times for pharmacists

Median application processing times for pharmacists (working days)		Median application processing times for pharmacy technicians (working days)	
Application receipt to approval	1.0	Application receipt to approval	0.0
Application receipt to entry	3.0	Application receipt to entry	8.0

Medians calculated for applications during the period 1st July to 30th September 2018

Application turnover for the period remains consistent. The median time for processing the applications for pharmacists has reduced to 1 day from previously reported medians of 2.5 days for the last quarter or 4 days for the same period last year. This is a positive improvement from the impact of the new Registrant Online Services process for pharmacists where we can measure from the date the application is complete.

1.4 Contact Centre

Phone	2016/17		2017/18				2018/19	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Calls made to GPhC	13,081	9,176	14,024	17,131	11,968	8,596	24,005	28,368
Calls answered within 20 seconds (KPI > 80%)	60.0%	62.6%	49.0%	67.5%	71.3%	89.4%	23.5%	27.5%
Calls abandoned (KPI < 5%)	9.8%	9.0%	11.8%	5.8%	5.9%	1.8%	38.0%	30.6%
Correspondence								
Emails actioned within 2 days (KPI > 90%)	80.0%	89.3%	98.6%	97.3%	99.6%	99.5%	51.9%	71.1%

We have received record volumes of both calls and emails handled by the CCC during this reporting period.

- Calls received of 28,368 is the highest total ever for one quarter, and the last 5 months have now seen 4 of the 5 highest monthly totals ever (May, July, August and September).
- Emails actioned of 12,472 is also the highest total ever for one quarter. The 3 highest ever monthly totals have been received in the last 5 months (May, August and September). Despite this, performance has increased with 71% of all emails received a response within 48 hours of receipt.

As reported for the last quarter, despite the fact that registrants have had to wait longer to speak to a member of the team, due to the decisions we have taken to guide registrants through the sign-up process which has extended the length of individual calls, the briefing and training provided to the CCC prior to the launch of revalidation has meant that the end result for callers has been positive due to the quality of the advice and assistance provided. We are also using resources flexibly with appropriately trained people in other teams responding to email questions about revalidation.

Of note, it is important to highlight that this is the busiest period of normal business for the CCC, for example providing;

- Support of new pre-registration trainees as they register for their pre-registration training for 2018-19.
- Support of trainees who passed the June registration assessment in getting them registered, and those who failed in what their options are next.
- Support for all pre-registration trainees sitting the Registration assessment in September, including all adjustment requests, application queries and issues about the day itself.
- Increasing numbers of queries around renewal, building towards the renewal deadline for the main cohort of 31 October 2018.

And then in addition, the CCC has been at the forefront of supporting a number of key initiatives that are in the process of being implemented across the GPhC this year;

- Implementation of the new myGPhC system, requiring every existing registrant to set up their new account.
- Implementation of the new revalidation requirements, and a need for all registrants to understand what they need to record, and how to do it.
- The first cohort being requested to actually submit their new revalidation records as part of the usual renewal process. This cohort is by far the largest, being c42,000 registrants whose renewal deadline is 31 October 2018.
- Implementation of the new online registration system, in time for registration of c2,500 successful candidates following the June assessment.

1.5 Continuing Professional Development

There will be no further reporting for the old model for CPD.

New reporting will commence after the renewal deadline of 31st October 2018.

2. Fitness to Practise (FtP)

2.1 Fitness to Practise performance standards

		2017/18			2018/19	
		Q2	Q3	Q4	Q1	Q2
All cases triaged during this period	No.	563	611	667	681	635
Of which cases triaged within 3 working days	No.	540	381	485	438	454
	%	95.9%	62.4%	72.7%	62.8%	71.5%
Of which cases triaged within 5 working days	No		532	601	576	556
	%		87.1%	90.1%	84.6%	87.6%
Of which cases were closed at triage					228	193
					33.5%	30.4%

The number of concerns received has dropped during this quarter which could be attributed to the summer period including the exceptional weather, the World Cup, Wimbledon, and the school summer holidays. There was a marked reduction in concerns compared to recent months but the upward trend on previous years continues. The average number of concerns received per month is now 220 down from 230 for this fiscal year. In comparison to Q2 2017/18, the total number of cases triaged has increased by 72 (12.8%). In August 2018 we received the second highest ever number of concerns within one month.

2.1 Fitness to Practise performance standards (cont.)

		2017/18			2018/19		
		Q2	Q3	Q4	Q1	From Q2 time measured in weeks	Q2
All stream 1 cases closed pre-IC	No.	153	212	223	249		129
Of which closed within 3 months	No.	127	177	193	209	Of which closed within 13 weeks	111
	%	83.0%	83.9%	86.5%	83.9%		86.0%
All stream 2 cases closed pre-IC or referred to the IC	No.	123	179	192	160		122
Of which closed or referred within 10 months	No.	106	148	144	120	Of which closed or referred within 44 weeks	93
	%	86.2%	82.7%	73.0%	75.0%		76.2%
All cases closed or referred at IC	No.	36	18	45	28		26
Of which reach IC within 12 months	No.	16	13	29	13	Of which reach IC within 52 weeks	12
	%	44.4%	72.2%	64.4%	46.4%		42.2%
All FTP committee cases closed	No.	29	18	24	17		20
Of which closed within 24 months	No.	18	14	17	7	Of which closed within 104 weeks	7
	%	62.0%	77.7%	70.8%	41.2%		35.0%

Our total number of cases being worked on at any one time has also increased but only by 29 (4%) in comparison to Q2 2017/18. Following a number of staff movements within the directorate during Q2, there has been a slight drop in productivity as capacity reduces to cover any vacancies. The number of cases closed pre-IC or referred to the IC however has remained on par with Q2 2017/18 and the number of cases closed within 10 months remains stable. Q3 has seen the start of a number of new members of staff who will need time to develop but in the short term will be able to relieve pressures on existing staff members. There remains a concerted effort to dispose of the oldest cases as well as keep the newer cases moving through the process in a timely manner.

As part of our work to improve data quality and consistency in trend reporting we have moved to reporting in weeks from this quarter onwards above.

2.2 Caseload age profile

Age profile		2017/18			2018/19		
		Q2	Q3	Q4	Q1	From Q2 time measured in weeks	Q2
Under 6 months	No.	447	443	459	458	Under 26 weeks	491
	%	58.3%	58.8%	60.8%	60.3%		61.7%
6-12 months	No.	177	157	153	152	26 - 52 weeks	142
	%	23.1%	20.9%	20.3%	20.0%[1]		17.8%
12-14 months	No.	24	30	22	39	52 - 65 weeks	48
	%	3.1%	4.0%	2.9%	5.1%		6.0%
15 months old and over	No.	119	123	121	110	65 weeks old and over	115
	%	15.5%	16.3%	16.0%	14.5%[2]		14.4%
Total	No.	767	753	755	759	Total	796
	%	100.0%	100.0%	100.0%	100.0%		100.0%

We have worked hard at trying to reduce our older case load as well as maintaining throughput in line with our KPIs. The directorate has prioritised 12-month cases which is evident when considering the data in the caseload age profile above against that of on hold cases below. The total increase in on hold cases over 12 months from Q1 to Q2 is 11. The total increase in cases over 12 months from Q1 to Q2 is 14. This is evident of the focus on cases over 12 months during the first half of the year because the bulk of these cases are now moving into the post-IC stage and being disposed of following a fitness to practise hearing.

From this quarter onwards, as part of our development to automate the report, we have updated these age profile groupings to weeks to align our units of measurements to those in the Professional Standards Authority dataset.

[1] Corrected from 20.7% in error in Q1 2018/19 report
[2] Corrected from 19.3% in error in Q1 2018/19 report

2.3 Cases over 12 months/52 weeks

Following feedback from Council, we have introduced the table below to illustrate the breakdown of cases on hold which are over 12 months/52 weeks old and what stage of the process they are at. This table shows the number of cases on hold separate to those which are actively being worked on at the pre-IC (the investigation stage) and post-IC stages (the preparation for hearing stage). Those cases on hold are with other authorities where we have stopped activity investigating so as not to conflict or prejudice the work of others. We are currently seeking advice on our policy about on hold cases in light of recent independent reports into healthcare and health professional regulatory failings.

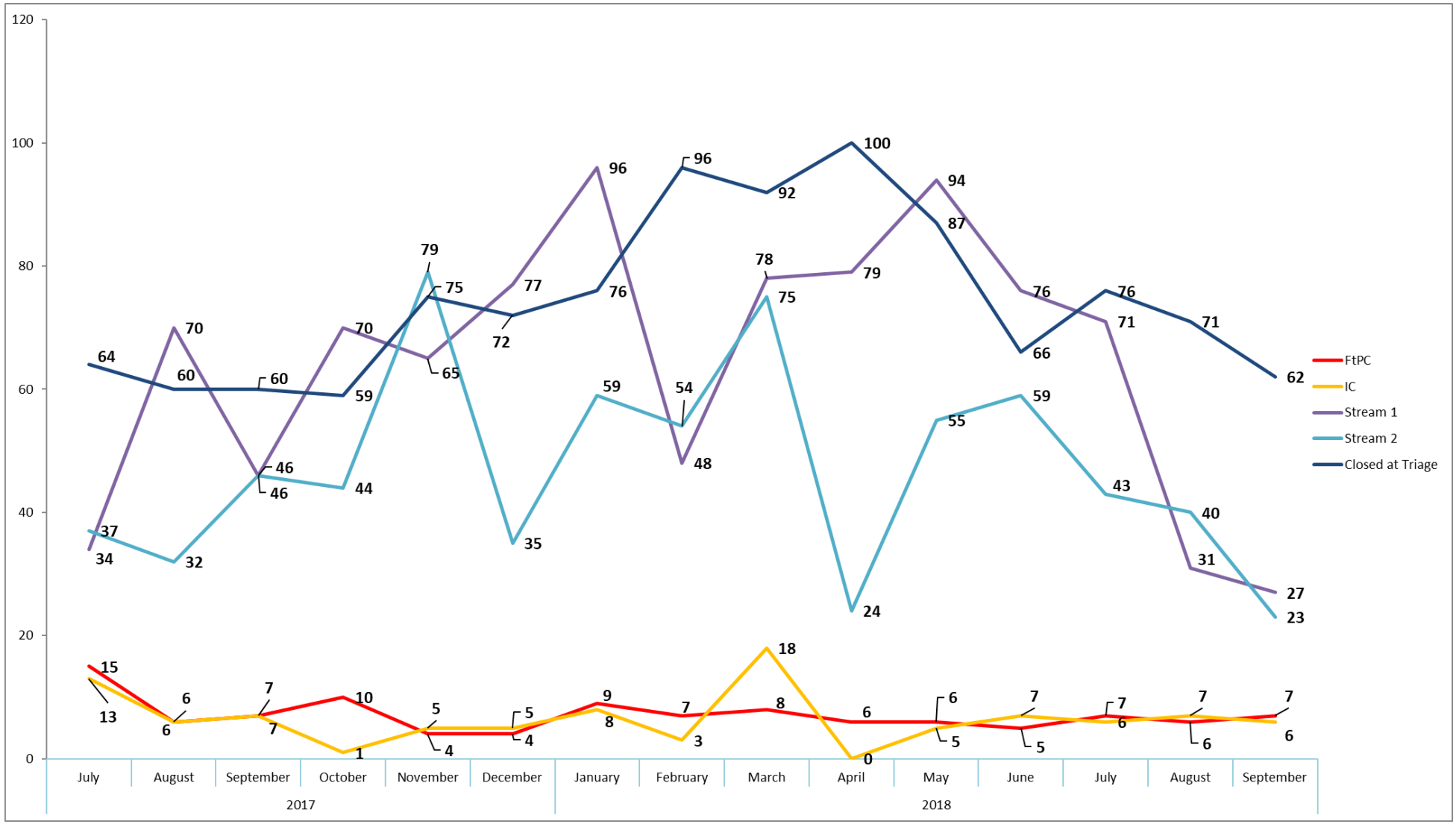
Status		2018/19	
		Q1	Q2
On Hold	No	36	47
	%	24.0%	28.8%
Pre-IC	No	45	56
	%	30.0%	34.3%
Post-IC	No	68	60
	%	46.0%	36.8%
Total	No	149	163
	%	100.0%	100.0%

2.4 Cases over 15 months

Age profile		2017/18			2018/19		
		Q2	Q3	Q4	Q1	From Q2 time measure in weeks	QError! Bookmark not defined.
15-19 months	No.	48	67	65	40	65 – 86 weeks	40
	%	40.3%	54.5%	53.7%	36.4%		34.8%
20-24 months	No.	29	17	20	34	86 - 108 weeks	35
	%	24.4%	13.8%	16.5%	30.9%		30.4%
25-29 months	No.	17	20	20	11	108 - 130 weeks	16
	%	14.3%	16.3%	16.5%	10.0%		13.9%
30-34 months	No.	11	10	6	14	130 - 152 weeks	10
	%	9.2%	8.1%	5.0%	12.7%		8.7%
35-39 months	No.	6	4	5	4	152 - 173 weeks	11
	%	5.1%	3.3%	4.1%	3.6%		9.6%
40-42 months	No.	2	2	3	3	173 - 186 weeks	1
	%	1.6%	1.6%	2.5%	2.7%		0.9%
43-49 months	No.	6	2	1	3	186 - 217 weeks	2
	%	5.1%	1.6%	0.8%	2.7%		1.7%
50 months or more	No.	0	1	1	1	217 weeks old or over	0
	%	0.0%	0.8%	0.8%	1.0%		0.0%

Although we have seen an increase in the number of cases over 12 months/52 weeks, the proportion of cases over 15 months/65 weeks has remained the same at around 14% (110 out of 759 in Q1 to 115 out of 796 in this quarter). The percentage of cases over 12 months as part of our overall caseload has also been steady at around 20% (149 out of 759 cases in Q1 to 163 out of 796 cases in Q2). The maintenance of these proportions highlights the focus in this area despite increases in some of the age brackets.

2.5 Cases closed by stage[3]



[3] The graph shows closures only. This excludes cases referred to IC as they are not deemed to be closed for the purposes of this graph.

2.6 DBS referrals

The GPhC's Disclosure and Barring Service (DBS) and Disclosure Scotland (DS) Referrals Panel met once and considered 1 matter during this quarter. This matter was referred to DBS (covering England and Wales) and none referred to DS.

2.7 Appeals

No appeals were brought in this quarter.

2.8 Interim Orders

The Fitness to Practise Committee considered 6 applications for interim orders during this quarter. There were no postponements. Four interim suspension orders were imposed (three for 18 months and one for 9 months). One order for interim conditions was imposed for 18 months and one application was refused with no order imposed.

During this quarter, the median period for the time taken from receipt of information identifying the need for a potential order and the application being heard increased to 1.9 weeks.

3. Inspection

3.1 Inspections undertaken

	Routine inspections	Follow up inspections	Visits before registration
Pharmacies	940	64	65

Figures above relate to inspection activity between 1 July 2018 and 30 September 2018.

The number of routine inspections decreased slightly from the previous quarter from 961 to 940. This is due to several factors including increased planned annual leave due to seasonal holiday periods during this quarter, the delivery of local presentations for the registered pharmacies consultation which closed in August, and a three-day inspection training event in September. It is also noted that the number of follow up visits increased from 48 to 64 in this quarter and there was also a small increase in the number of visits before registration.

3.2 Pharmacy premises not inspected

Months since previous inspection		2017/18			2018/19		
		Q2	Q3	Q4	Q1	Weeks since last inspected	Q2
36-38 months	No.	505	627	734	591	156 - 169 weeks	686
	%	14.5%	19.5%	25.0%	20.7%		21.5%
39-41 months	No.	558	510	615	718	169 - 182 weeks	676
	%	16.0%	15.9%	21.0%	25.1%		21.2%
42-47 months	No.	1,004	984	986	1014	182 – 208 weeks	1,171
	%	28.7%	30.6%	33.6%	35.5%		36.6%
48 months or more	No.	1,426	1,095	599	533	208 weeks or more	663
	%	40.8%	34.0%	20.4%	18.7%		20.7%
Total	No.	3,493	3,216	2,934	2,856	Total	3,196
	%	100.0%	100.0%	100.0%	100.0%		100.0%
Of all registered pharmacies	No.	14,404	14,417	14,348	14,332	Of all registered pharmacies	14,323
	%	24.25%	22.3%	20.5%	19.9%		22.3%

Figures correct as at 30th September 2018

The number of pharmacies not inspected for 36 months or more has increased this quarter from 2,856 to 3,196. This represents a small increase in this quarter although the numbers remain relatively low compared to historical figures. This results from several factors including the way we count inspections (see footnote above), a lower number of routine inspections undertaken this quarter and fluctuations each month due to historical spikes in inspection activity. For the sixth quarter in a row, there are no pharmacies in the sixty plus months category during this performance period.

In our drive to develop and automate our report, from this quarter onwards we have moved to reporting in weeks to avoid variances in reporting periods and comparing between different datasets.

3.3 Age profile of pharmacies not inspected for 48 months and over

Weeks/Months since previous inspection		East	North	South	West	Total
208 - 221 weeks (48 – 50 months)	No.	109	87	145	61	402
	%	58.0%	52.7%	67.1%	64.9%	60.6%
221 - 234 weeks (51 – 53 months)	No.	68	59	67	24	218
	%	36.2%	35.8%	31.0%	25.5%	32.9%
234 - 260 weeks (54 – 59 months)	No.	11	19	4	9	43
	%	5.9%	11.5%	1.9%	9.6%	6.5%
260 weeks or more (+60 months)	No.	0	0	0	0	0
	%	-	-	-	-	-
Total	No.	188	165	216	94	663
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Figures correct as at 30th September 2018

In this quarter, the number of pharmacies not inspected for over 54 months/234 weeks increased from 24 to 43. However, the number remains low compared to historical figures as our inspectors continue to focus on pharmacies in their area which have not been inspected for the longest period. The age profile will however continue to fluctuate month by month due to previous historical spikes in geographical areas. To help manage this variation, we continue to deploy our inspectors in a flexible way, using inspectors within regions to assist colleagues in different areas, as well as across regions.

The calculations for this table have been updated to weeks from this quarter onwards to avoid variances in reporting periods.

3.4 Top 5 standards ranked as not met

Standard no.	Description		Q1 Rank
4.3	Medicines and medical devices are: obtained from a reputable source; safe and fit for purpose; stored securely; safeguarded from unauthorized access; supplied to the patient safely; and disposed of safely and securely	58	1
1.1	The risks associated with providing pharmacy services are identified and managed	58	2
4.2	Pharmacy services are managed and delivered safely and effectively	39	4
1.2	The safety and quality of pharmacy services are regularly reviewed and monitored	37	5
1.6	All necessary records for the safe provision of pharmacy services are kept and maintained	30	6
2.1	There are enough staff, suitably qualified and skilled, for the safe and effective provision of the pharmacy services provided	30	3

The top 5 standards ranked as 'not met' have changed slightly with Standard 4.2 moving up to 3rd place ranking, and Standard 1.6 moving up to equal 5th ranked 'not met' standard. Standard 2.1, which we continue to monitor closely, and relates to the adequacy of staffing, has dropped two places this quarter and is now ranked equal 5th out of the 'not met' standards.

Standard 4.3 remains the highest ranked standard this quarter. Typically, the sorts of issues that were found related to the adequacy of systems in place to prevent access to controlled drugs; monitoring of fridge temperatures and the adequacy of date checking processes.

Standard 1.6 has entered the top 5 'not met' standards this month and relates to record keeping. Typically, the sorts of issues found by the inspectors included poor management of controlled drugs records; incomplete private prescription records and incomplete responsible pharmacist records.

3.5 Top 5 standards ranked as good

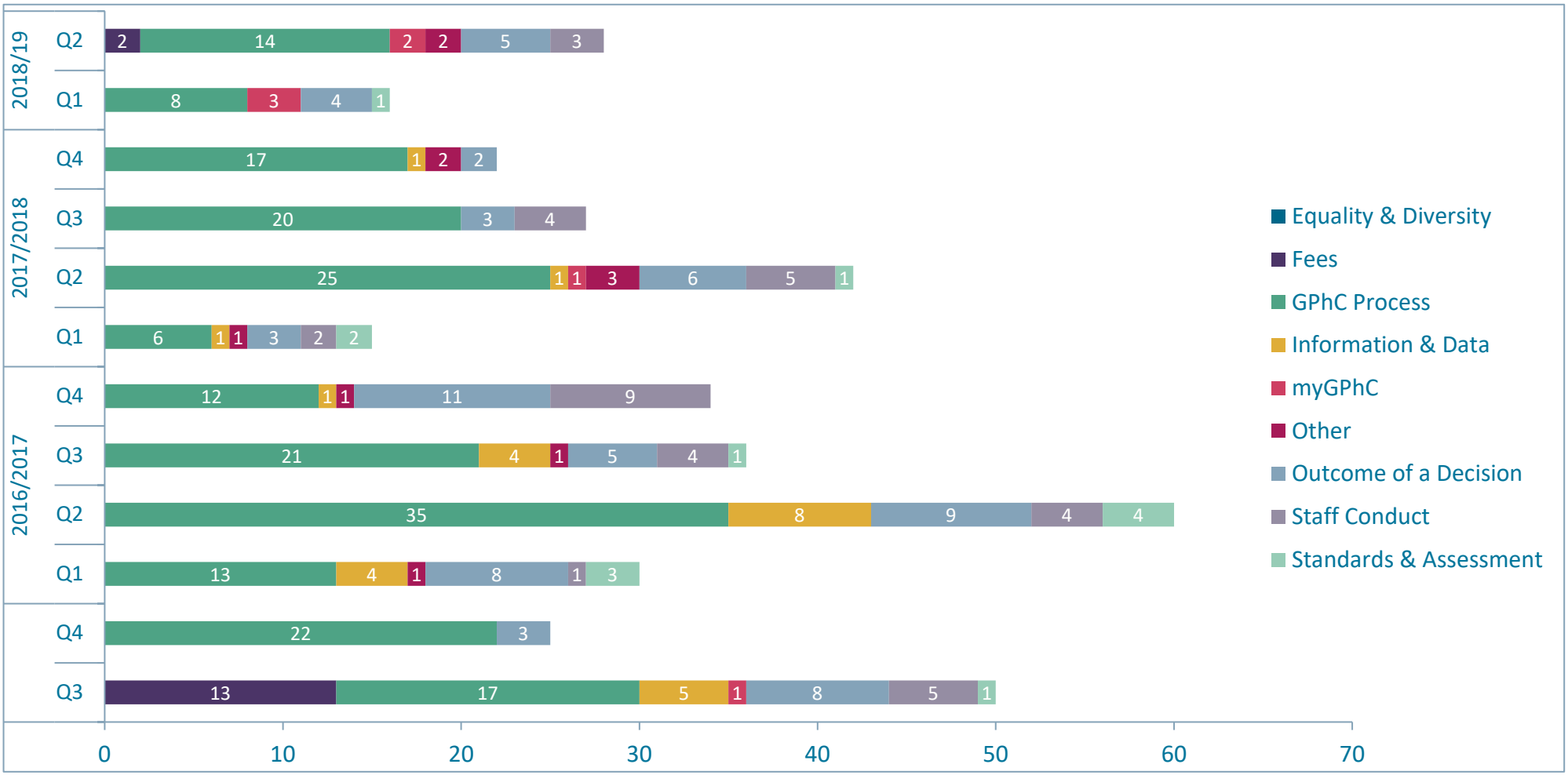
Standard no.	Description		Q1 Rank
2.2	Staff have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training	256	1
2.4	There is a culture of openness, honesty and learning	206	2
1.2	The safety and quality of pharmacy services are regularly reviewed and monitored	206	3
1.1	The risks associated with providing pharmacy services are identified and managed	137	4
2.5	Staff are empowered to provide feedback and raise concerns about meeting these standards and other aspects of pharmacy services	134	6

The above rankings relate to inspections carried out between 1 July 2018 and 30 September 2018.

The top five 'good' standards have remained relatively stable apart from standard 2.5 (which was previously ranked 6th) entering the top 5 'good' standards, and standard 4.2 dropping out.

4. Complaints

4.1 Formal complaints and negative feedback by category



Figures correct as at 30th September 2018

4.1 Formal complaints and negative feedback by category (cont.)

The second three months of 2018/19 has seen a continuation of two significant trends: the ongoing annual cycle in which there is a large percentage increase in complaints compared to the first three months of the year; and a continued reduction in the overall volume of complaints. A total of 28 complaints were received by the GPhC in Q2, a reduction from the 32 in the same time during 2017/18.

In the PMR for Q1, the possibility was raised of a future increase in complaints about myGPhC due to the new online registrant services. While the two such complaints received in Q2 is more than at this time last year, no significant upturn has occurred. Again, this is a positive reflection on the technical work done to date to introduce new online services.

GPhC processes continue to represent the largest category of complaints, with 14 received. Complaints about the outcome of a decision was the next highest category, followed by staff conduct. No complaints have been received on equality and diversity for over two years, but complaints (2) were received this quarter on fees for the first time since Q3 of 2015/16. No underlying cause has been identified for these. We will continue to monitor this category and comment further in the next PMR.

All but two of the complaints have reached the decision stage. 19 complaints were not upheld, three were partially upheld and six were upheld. One upheld complaint was in relation to confusion over evidence to present at a hearing, while another resulted from how a committee decision was communicated. The remaining four upheld complaints pertained to delays in Customer Services either in processes or responses to queries. The three partially upheld complaints related to the level of service received from the Customer Services and Applications teams. While the actual online portal for registrant services has not received many complaints, the volume of queries to Customer Services Team was higher than anticipated and led to significant work pressure. This context is likely responsible for the increase in upheld and partially-upheld complaints, and has been taken as a lesson learned for the development of further online services.

5. Education

5.1 Accreditation and recognition activity

Course	Type	2016-17 academic year				2017-18 academic year			
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Master of Pharmacy (MPharm) degree 4-year	Accreditation	1	4	4	-	1	1	2	
	Reaccreditation	-	-	-	-	-	1	6	1
	Interim visit	-	5	-	-	1	5	-	-
Master of Pharmacy (MPharm) degree 5-year integrated	Accreditation	-	-	-	-	-	2	1	
	Reaccreditation	-	-	-	-	-	-	-	
	Interim visit	-	-	-	-	-	-	-	
Master of Pharmacy (MPharm) degree 2+2 Overseas	Accreditation	-	-	-	-	-	-	1	-
	Reaccreditation	-	-	-	-	-	-	1	-
Overseas pharmacist assessment programme (OSPAP)	Reaccreditation	-	-		-	-	1	- 1 -	- 1 -
Independent prescribing	Accreditation	1	1	1	-	1	-	2	-
	Reaccreditation	2	3	8	4	5	3	5	1
	Monitoring visit	2	-	1	3	0	-	1	1
Level 3 Pharmacy technician knowledge/competence	Approval/Accreditation	-	-	-	-	-	-	-	-
	Reaccreditation	-	-	-	-	-	-	-	-
Level 2 medicines counter assistant and dispensing assistant	Accreditation	-	-	-	-	-	-	-	-
	Reaccreditation	-	-	-	-	-	-	-	2

5.1 Accreditation and recognition activity (cont.)

All events went ahead as scheduled.

A high volume of events scheduled and have taken place for the 2017-18 academic year, particularly for MPharm degrees and independent prescribing programmes. The MPharm and OSPAP events would have taken place between January – July 2018, and prescribing events throughout the calendar year. The large number of events this academic year is due partly to natural peaks in the accreditation cycles but also to an increased interest from providers in provision of 5-year integrated MPharm degrees, and in the increase in the need for pharmacist prescribers which has led to increased funding for pharmacist prescribing programme places, resulting in interest from new course providers. 47 independent prescribing programmes are currently accredited.

Level 2 courses were granted an extension from January 2018 – July 2018 due to the consultation on safe and effective staff. Following the Council meeting in May 2018 it was agreed that the Level 2 courses continue business as usual after the consultation activity was put on hold.

6. Human Resources

6.1 Headcount Overview

GPhC	30th September 2018
Headcount	**238**
Permanent	217
Fixed Term Contract	21
Total Leavers	**15**
Permanent leavers	15
Turnover – Permanent (July - Sept)	**6.9%**
Turnover – Permanent (Year to Date) April – Sept	**13.4%**
Stability – Permanent staff	**79%**

The data above summarises the headcount position during the period of 1st July to 30th September 2018. The total number of leavers for this period was 15 permanent employees. The turnover rate for permanent staff excludes those employees who were/are on a fixed term contract.

The total number of permanent leavers for this specific period equates to a turnover rate of 6.9%. The turnover rate fluctuates between quarters with a lower rate of 5.2% reported in the last quarter and a higher turnover rate of 12.4% reported in the same period last year in Q2 of 2017/18. Survey data suggests average turnover for organisations of less than 250 employees is 21.6%.

The stability rate has been calculated based upon the number of permanent employees with more than 12 months employment at GPhC. On the 30th September 2018, there were **187** permanent employees who had more than a 12-month employment at GPhC. The stability percentage fluctuates between quarters and has decreased from the previous figure of 85% in the last quarter but has increased from 76.5% from the same period last year, Q2 2017/18. We are monitoring this.

6.2 Organisational Absence – Absence Percentages (July 2018 – September 2018)

Directorate	Absence %
Organisation	**1.8%**
Corporate Resources	2%
Education & Standards	1.5%
Fitness to Practise	2.7%
Insight, Intelligence & Inspection	0.7%
People	2.8%

The table above details the absence percentages for the organisation and the individual Directorates at GPhC. In total 276.6 working days were lost due to absence in this period compared to a loss of 322 working days (lost) due to absence in the last quarter from April to June 2018. The absence percentage has decreased from 2.1% to 1.8% from Q1 to Q2.

Data cleansing of absence records has occurred. Training in the HR Information System is routinely offered for reporting purposes. Positive return procedures are being relaunched in the current quarter, recognising the impending autumn / winter illness season.

Benchmarking	Absence %
GPhC in 2016	**2.0%**
CIPD - All Organisations	3.3%
CIPD - Central Government	4.8%
CIPD - Local Government	4.6%
CIPD - Health	4.8%

6.3 Employee Relations

The table below is a summary of the employee relation cases by case type which are live during the specified period:

Case Type	No. of cases
Total Cases	**5**
Absence	2
Grievance / Disciplinary	2
Performance	1
Other	0

6.4 Learning & Development

L&D have continued to support the organisation with emphasis this quarter in strengthening inclusivity. Initiatives have included: the launch of the quarterly Corporate Induction workshop, supporting the organisation on the performance appraisal process, developing twelve employees across GPhC to be Mental Health First Aiders and coordinating customised internal workshops for FtP.

L&D have designed and developed a one-day interactive Corporate Induction workshop for new joiners which started in July. The objectives of the workshop are: to build awareness of the history of pharmacy, healthcare systems and our regulatory role, provide an overview of who we are and what we do, and help new joiners familiarise with our values and culture. This work forms part of our work to improve the onboarding and integration of new starters and reduce the attrition rates of employees with less than one year's employment. Eighteen new joiners attended and L&D received excellent feedback. 100% of attendees who submitted the feedback agreed or strongly agreed that the induction gave them a better understanding of the whole organisation, how other teams' work, our values and culture.

In Q1, L&D had implemented Phase 1 of the online Performance Development Review process (Initial PDR). The implementation involved a mix of learning resources and support to help employees familiarise with the new system. 87% of employees completed phase 1 which is a great improvement to the paper-based process. The new approach and system demonstrates a more self-directed approach, allowing employees to be more accountable and link their personal contribution and performance to the Annual Plan and Strategic Aims. As part of continuous learning and improvement, we conducted a survey regarding the online system and overall, we received excellent feedback: 86% of responses found the PDR system easy or very easy to use, 93% of responses found the resources useful or very useful and 92% of responses are confident or very confident in using the system for the Mid-year review. L&D have taken on board all positive and constructive feedback and are working towards making the PDR process even more efficient.

In August, L&D delivered our first internal Mental Health First Aid (MHFA) workshop with 12 employees across GPhC becoming Mental Health First Aiders. MHFA is designed to teach people how to spot the signs and symptoms of mental ill health and provide help on a first aid basis. In general, the role of a Mental Health First Aider in the workplace is to be a point of contact for an employee who is experiencing a mental health issue or emotional distress.

L&D coordinated the customised internal workshop, 'Handling Difficult Conversations' for FtP in September. The one-day workshop built skills on how to manage investigative and challenging conversations more effectively. Regarding the nationally recognised 'Advanced Professional Certificate in Investigative Practice' we are pleased to report that all sixteen delegates passed and gained the qualification. This has helped employees build advanced knowledge in Law, Evidence, Procedure, Report Writing, Giving Evidence and Investigative Interviewing thus ensuring a highly skilled workforce in quality investigative practice. This initiative demonstrates GPhC's commitment to professional career development and employees' commitment to manage work duties and academic study. To recognise their achievement, a certificate ceremony by our Chief Executive was arranged.

Annual plan progress report 2018/19

Quarter 2: July – September 2018

Introduction

This report provides an update on the key strategic priorities in our Annual plan 2018/19.

The reporting period covers quarter 2, July to September 2018.

Overview

Strategic Priorities	Status	Direction of travel
Building our data, information, intelligence and insight capability	A	↓
Developing our approach to fitness to practise	R	↓
Securing assurance and promoting improvement in registered pharmacies	G	→
Improving standards of care through regulation of education and training	G	↑
Transforming our organisation, our services and processes	A	→

Key

Status/direction of travel	Definition
R	Significant issues, aims may not be met to time/budget
A	Some issues emerging, aims still achievable
G	On track/completed
B	Not started
↑	Rating Improved from last period
↓	Rating worsened from last period
→	Rating from last period unchanged

Building on our data, information, intelligence and insight capability

RAG	Direction of travel
A	↓

Strategic aim:

- **The pharmacy team have the necessary knowledge, attitudes and behaviours**
- **Registered pharmacies deliver safe, effective care and services**
- **Pharmacy regulation is efficient and effective**

In 2018/19 we will:

- Develop a phased insights and intelligence strategy to improve our capacity and capability to report, learn from and act on our work more efficiently
- Improve the quality and consistency of the data that we hold for key statutory and governance performance reports and the supporting data infrastructure
- Share the insights from what we have learned from inspections of registered pharmacies to date
- Conduct a registrant workforce survey to inform our work and that of stakeholders
- Continue to update our data approach and procedures to ensure compliance with the General Data Protection Regulation (GDPR)
- Create the development framework for a pilot organisation wide enquiry hub to receive, co-ordinate and analyse all incoming information and concerns to inform more proactive and tailored regulatory responses at an earlier stage

What does success look like?

- A clear insights and intelligence strategy in place guiding our priority areas for action
- Standardised and automated reporting of statutory and governance performance reports
- Published insights from inspections of registered pharmacies are being used to inform and drive improvements in pharmacy practice
- Up to date baseline established of what pharmacy professionals are doing and where
- No personal data breaches reportable to the Information Commissioner's Office
- Information rights requests responded to appropriately and within time limits
- Overall development framework in place with phase one pilot of an enquiry hub (enhanced triage) in Fitness to Practise up and running; (this pilot is being reported under 'Developing our approach to Fitness to Practise')

Key links and assumptions

- Resources for all business teams are available to do this work and teams will work collaboratively with support from senior leaders and managers
- The volume of data and information requests remains stable so that there is capacity to do this work
- Partner organisations must be engaged and have resources

Main risks

- If resources (capacity and capability) are not available, work will take longer to complete

Outline timetable:

April-June 2018	July-September 2018	October-December 2018	January-March 2019
• Complete baseline mapping of existing data sources across the organisation to inform the Insights and Intelligence strategy • Commence end to end review and design for the automation of the production of key statutory and governance reports • Commission research on what we have learned from our current approach to inspecting registered pharmacies • GDPR e-learning training sourced and implemented • Internal data protection policies and procedures updated • Website and myGPhC privacy policies updated • Consultation on publication and disclosure policy begins • New data protection contract clauses and schedules sent to suppliers of priority contracts	• Complete standardisation and automation of Professional Standards Authority (PSA) data sets • Commence development of automated Council Performance Monitoring Reports • Begin research on learning from our inspections of registered pharmacies to date • Scope requirements for a registrant survey • Supplier contract GDPR variations completed • Further tailored GDPR training for key functional areas developed and dates planned	• Insights and intelligence strategy presented to Council including priority areas of focus with plan • Operational data warehouse developed to include addition of datasets • Research on learning from inspections finalised • Identify options to conduct and analyse registrant survey • Publication and disclosure policy finalised • Personal data processing records reviewed and updated • Further GDPR tailored training launched • Development framework for a pilot organisation wide enquiry hub completed	• Continued standardisation and consolidation activities for data • Conduct registrant survey • GDPR compliant information sharing agreements in place for key Memorandum of Understanding (MoU) partners • Tailored GDPR training continues • Develop a public perceptions survey

Commentary for Q2:

Data, Insights and Intelligence

There has been good progress on the areas scheduled for completion in this quarter's performance period. Standardised and automated PSA dataset reports are now up and running. This has involved the building of a new reporting operational database with quality assurance designed in. For example, this includes the revision of data dictionaries with business definitions of data fields, through to documentation and sign-off of calculations with business owners and audit tables, providing an end to end approach to improving data quality. This importantly includes identification of new exception reports to support business teams in improving data quality at data entry stage – i.e. what goes in. Such an approach is a key step towards achieving sustainable data quality sources and efficient and effective reporting, a key priority of our Insights and Intelligence Strategy framework. Work has also started on bringing in additional data to the operational reporting database to begin to automate the Council Performance Monitoring Reports where possible.

Research on the learning from our inspections of registered pharmacies has been progressing well and is on track to be finalised by the next quarter.

Work to scope the requirements for a registrants' workforce survey has almost completed. This has included engagement with key stakeholders in England, Scotland and Wales and internally to review questions. The survey is not scheduled to be initiated until quarter 4 and we will be exploring options for commissioning the work externally or investing in new software and staff training to deliver this internally.

GDPR Compliance

Contract variations have been completed for existing suppliers but follow up work is required with some suppliers to finalise terms. Progress is being made on a new procurement policy and supporting training to ensure that all new procurement activity takes GDPR requirements into account.
The volume and nature of information requests received in the second quarter under data protection and freedom of information legislation and the need to meet statutory deadlines has meant that timelines for the remainder of the year for other improvement work are now at risk of overrunning.

The overall RAG status is amber due to delays to completing scheduled GDPR activities this quarter because of the volume and nature of information requests received and being managed. There has been good delivery against other activities outlined in the timetable.

Developing our approach to fitness to practise

Strategic aim: **The pharmacy team have the necessary knowledge, attitudes and behaviours**

RAG	Direction of travel
R	↓

In 2018/19 we will:

- Develop a strategy for the future of fitness to practise (FtP) that is focused on protecting the public whilst being more restorative and less adversarial in our approach. We will draft a consultation document to support this
- Undertake and evaluate pilots to inform the development of the strategy including an enquiry stage (enhanced triage) and the use of pre-Investigating Committee undertakings
- Improve how we categorise the concerns we receive to better understand our caseload and draw out any insights for the strategy development
- Ensure that the future FtP strategy reflects the learning from the health professions sector and recent inquiries and reports
- Undertake the planning for an external review which will look at the links between our fitness to practise processes and the mental health implications for those involved, including registrants, complainants and witnesses. The review will be carried out in 2019/20

What does success look like?

- The draft future FtP strategy is drafted and ready for consultation
- The draft strategy clearly sets out our ambition; always taking prompt action on serious concerns and being proportionate, fair and timely in the use of regulatory powers
- Our developing draft fitness to practise (FtP) strategy is informed by wider sector learning, including from the Williams review, Gosport inquiry, other regulatory reviews and other regulators as well as from our own internal pilots and developments
- We will have a clear plan for the delivery of the external review. The plan will include how pharmacy sector stakeholders are to be involved and some of the activities

Key links and assumptions

- We will have a public consultation on the future fitness to practise strategy which will incorporate aspects of the work on assessing the impact on mental health
- The new director of FtP will want to take an overview of the development of the strategy during Q4 2018/19

Main risks

- Availability of review panel members to engage with the planning of the mental health and FtP review
- Limited resources in terms of capacity to complete the ongoing work as well as delivering the regulatory function

Outline timetable:

April-June 2018	July-September 2018	October-December 2018	January-February 2019
• Develop draft strategy and key associated initiatives • Background work on mental health and FtP including reviewing work undertaken by other regulators • Research and planning on planned pilots and improvements to categorisation	• Consultation approach agreed with Senior Leadership Group • Enquiry and Pre-Investigating Committee undertakings pilot launched • Agree terms of reference and glossary for mental health and FtP • Appoint review panel for mental health and FtP	• Review process and identify key changes that can be made in-house • Launch revised categories • Evaluation of pilots and strategy development • Plan stakeholder event for mental health and FtP	• Implement any internal recommendations • Plan consultation for launch in early 2019/20

Commentary for Q2:

Progress has been made on the development of the draft FtP strategy with a draft vision now set out. This will now be discussed internally and tested within the directorate and with colleagues at the directorate away day.

Anticipating the arrival of a new director, the strategy work in the immediate future will now focus on planning how best to test the approach to handling concerns with a wider set of stakeholders and refine it as a result of those discussions. Research on changes to fitness to practise in the health professions sector will continue as well.

This work, and that of developing our consultation approach, has been reprioritised due to volume of concerns received and turnover within the directorate, including preparation for the departure of some senior colleagues who are either moving on or going on maternity leave. The activity related information can

be seen in the performance monitoring report to the end of September 2018. Work is underway to address the challenges that the directorate currently faces. The operational focus remains on delivering timely and proportionate investigation outcomes in line with our previous success in meeting the PSA's standards of good regulation.

To aid our overall approach to strategy development we have met with the NMC as they have recently completed a consultation on their future strategy and are now in the delivery phase. The result of our meeting was an insight into the potential risks and an understanding of the Professional Standards Authority's (PSA) current thinking with regard to FtP.

The approach and materials for both pilots identified for launch in Q2 are in place. What remains is the identification and allocation of resources to ensure the pilots are a success and the impact on operational functions is minimal. This has been hampered by the same reasons as above as well other internal pressures that have impacted on the sign off for some pieces of work.

The terms of reference for the mental health review have been approved internally but have not been agreed with the key partner organisations as of yet. Following a change of Chief Executive at Pharmacist Support we now need to establish their current capacity to be involved in the project.

The overall RAG status is red and reflects the current position of the strategy development for the reasons set out above. Future progress reports will outline any changes to the planned delivery of projects as a result of the delays this quarter.

Securing assurance and promoting improvement in registered pharmacies

Strategic aim: The pharmacy team have the necessary knowledge, attitudes and behaviours

RAG	Direction of travel
G	

In 2018/19 we will:

- Agree with government a timetable for commencing new powers to publish inspection reports, and share learning to promote improvement
- Consult on and implement our approach to publication of inspection reports and our updated proposals on pharmacy inspection
- Implement new enforcement powers to ensure our standards are met in registered pharmacies
- Build understanding among our stakeholders of our powers and tools for regulating both individual members of professions and pharmacy owners
- Issue guidance to pharmacy owners to support safe and effective care by all staff within the pharmacy team

What does success look like?

- Outcomes of inspections of registered pharmacies are easily accessible and transparent to members of the public, the pharmacy sector and other stakeholders, providing assurance and driving continuous improvements in the quality of pharmacy practice
- Stakeholders are clear on how their views informed the approved approach to regulating registered pharmacies
- The sharing of insights from inspections of registered pharmacies are used to inform improvements in the sector
- Pharmacy owners are clear on how our enforcement powers will be applied when standards are not met
- Pharmacy owners are clear what the regulator's expectations are for a safe and effective pharmacy team
- Key stakeholders have a basic understanding of our role, powers and tools for regulating professionals and owners

Key links and assumptions

- Publication of inspection reports by the end of March 2019 is dependent upon approval of the refined inspection approach in December 2018 and the build of the reporting web site with supporting infrastructure

Main risks

- Until the outcome of the consultation is available, it is unclear whether our proposals will draw broad support from the public and the sector
- The development of the IT infrastructure is the key building block for the publication and implementation of the refined inspection approach within the current timelines
- Limited external interest in, or engagement with, our work among key stakeholders at a time of significant challenge within pharmacy, health and government
- Publication of inspection reports exposes us to greater scrutiny relating to consistency of our decisions on inspection, factual accuracy of reports and potential legal challenge

Outline timetable:

April-June 2018	July-September 2018	October-December 2018	January-March 2019
• Worked closely with the Government to agree the timetable for commencing the Pharmacy (Premises Standards, Information Obligations etc) Order 2016 • Guidance for pharmacy owners to ensure a safe and effective pharmacy team published and promoted to all owners and pharmacy professionals, to raise awareness of what is expected of pharmacy owners • Consultation on developing our approach to regulating registered pharmacies published • The consultation included a summary of our new enforcement powers and the principles of our approach to enforcement which will help increase stakeholder understanding of our powers and tools • Commissioned research to inform our approach to registered pharmacies and drive improvement in the sector	• Consultation on developing our approach to regulating registered pharmacies closes • Research begins on what we have learned from our current approach to inspecting registered pharmacies • Develop new enforcement policy, engaging with key stakeholders to help inform the policy and increase their awareness of our powers and tools • Publish discussion paper on new proposals to protect people trying to obtain medicines online, setting out our powers and tools to regulate online pharmacies • Hold meetings with ministers and other key parliamentarians in three countries of GB, and with leading patient organisations, to explain our role, powers and tools for regulation	• Analysis of data and publication of research on what we have learned from our current approach to inspecting registered pharmacies. Research promoted to all key stakeholders • Analysis report of our approach to regulating registered pharmacies shared with Council and published. Communications activity to highlight what we heard through consultation activity • Approach to publication and the way we inspect registered pharmacies agreed with Council; promotion of new approach to all key stakeholders to build understanding and awareness • Publish our new enforcement policy and communicate this to all key stakeholders • Publish updated guidance on supplying medicines at a distance and promote this new guidance to all key stakeholders. Use publication as an opportunity to explain our role and how we work with other regulators in this area	• Start implementation and communication activities for the publication of inspection reports and agreed refinements to our approach to inspection • Promote publication of inspection reports to all key stakeholders to help increase awareness of our role in inspecting pharmacies and new publication powers

• Developed new public affairs strategy and taken forward a series of meetings with parliamentarians and other stakeholders to build understanding and awareness of our role			

Commentary for Q2:

Agree with government a timetable for commencing new powers to publish inspection reports, and share learning to promote improvement
Our work to share what we have learned from inspection has progressed well in this quarter. We have now inspected all registered pharmacies across Great Britain at least once and we have commissioned external research which included quantitative analysis of 14,650 reports and qualitative analysis of a representative sample of inspection reports to inform our understanding of what we have learned. We are on track to complete the analysis by December 2018.

Consult on and implement our approach to publication of inspection reports and our updated proposals on pharmacy inspection
Our work to implement refinements to our approach to inspecting registered pharmacies has progressed well in this quarter. The consultation closed on 9 August 2018 with 812 responses. We held three stakeholder engagement events in Edinburgh, Cardiff and London together with 22 local events led by inspectors. We also commissioned a YouGov survey involving 2040 adults across Great Britain, to inform our approach, and which built on public engagement reported in previous quarters. We are on track to share the analysis report on the consultation responses with Council in November, followed by Council decision on the proposals in December.

Implement new enforcement powers to ensure our standards are met in registered pharmacies
Our work to develop an enforcement policy has progressed well in this quarter to encompass the new powers that were given to us in May 2018. This work has included engagement with our legal, inspection and fitness to practise teams to help develop the policy, which will be used to ensure proportionate and consistent decision-making about when we use our powers. The policy is in draft form and will be supported by operational guidance. We are on track to have a final version of the policy available to be in place before Council in December.

Discussion paper on making sure patients can obtain medicines and other pharmacy services safely online
We have made good progress this quarter in engaging with stakeholders on the discussion paper published in June 2018 to find out their views on our proposals to strengthen our guidance on supplying pharmacy services at a distance. We held a roundtable event to engage with providers and relevant stakeholders from the sector and we commissioned a YouGov survey involving 2040 adults across Great Britain, as part of the registered pharmacies consultation, to inform our approach. The YouGov survey asked the public for their views on their experience of on line consultations, to include the

information they were given about the medicine they received; the identity of the prescriber and the pharmacy or pharmacist supplying the medicine. Responses to the discussion paper closed on 21 August 2018 with 797 responses. We are on track to share details of the outcome of our engagement with the sector and the public with Council in the next quarter.

Build understanding among our stakeholders of our powers and tools for regulating both individual members of professions and pharmacy owners
In this quarter, we have made good progress to build understanding among our stakeholders of our powers and regulatory tools. We met with key stakeholders including the ministers with responsibility for pharmacy in each of the three countries we regulate. During these meetings we discussed our proposals to develop our approach to regulating registered pharmacies, and the ministers expressed their support for our direction of travel, and the publication of inspection reports and the move to unannounced inspections.

The overall RAG status and direction of travel for the key pieces of work associated with the delivery of this priority area remains the same as the previous quarter (green) This reflects the good progress made against the actions planned for this quarter, the majority of which cover the continuation of work already underway.

Improving standards of care through regulation of education and training

RAG	Direction of travel
G	↑

Strategic aim: The pharmacy team have the necessary knowledge, attitudes and behaviours

In 2018/19 we will:

- Implement our new revalidation framework to provide assurance that pharmacy professionals continue to meet the required standards of professionalism throughout their careers
- Implement new standards for the initial education and training for pharmacy technicians working with course developers and providers
- Consult on, review and agree new standards for pharmacist independent prescribers followed by implementation activities with course developers and providers
- Initiate our work to review and consult on initial education and training for pharmacists so that initial education provided will meet the future needs of the public in relation to pharmacy services

What does success look like?

- Registrants will be able to renew and submit their revalidation records to demonstrate more effectively they are keeping up-to-date and reflecting on the benefit of their learning and practice on the people who use their services
- Revised standards for education and training for pharmacy technicians, pharmacist independent prescribers and pharmacists provide assurance that pharmacy professionals are fully equipped to play a leading role in the future of multi-professional healthcare
- Course providers for pharmacy technicians, pharmacist independent prescribers and pharmacists meet our new standards effectively through our accreditation or recognition processes

Key links and assumptions

- Stakeholders will support direction of travel for new pharmacist initial education training standards
- Courses based on new initial education and training standards for pharmacy technicians will be ready for accreditation at the end of 2018/start of 2019 so they are ready for delivery in September 2019
- Courses based on new education and training standards for pharmacist independent prescribers are ready for accreditation in early 2019

Main risks

- Late sign up for the new version of MyGPhC
- Our proposals for pharmacist IET standards cannot be delivered due to opposition from stakeholders

Outline timetable:

April-June 2018	July-September 2018	October-December 2018	January-March 2019
• Revalidation: Further revalidation guidance and examples published • Education: Analyse responses to pharmacist independent prescribing standards consultation • Education: Engagement with pharmacy technician course developers and providers • Education: Engagement with three new working groups for the development of the pharmacist IET standards	• Revalidation: The next phase of revalidation development to go live • Education: Workshops on elements of pharmacist IET standards • Education: Prepare papers for Council on pharmacist independent prescribing • Education: Continued engagement with pharmacy technician course developers and providers	• Revalidation: Recruitment and selection of revalidation reviewers • Education: Launch pharmacist IET standards consultation • Education: Put proposal for policy on non-registered pharmacy staff to Council • Education: Accredit new courses based on pharmacy technician IET standards • Education: Agree revised IET standards for pharmacist independent prescribers following consultation • Education: Present revised proposals for the education and training of non-registered pharmacy staff	• Revalidation: Preparation for first revalidation reviews • Revalidation: The next phase of revalidation goes live. • Revalidation: Council review of evaluation approach for revalidation • Education: Begin analysis of pharmacist IET standards consultation • Education: Begin accreditation of courses based on new Education and Training (ET) standards for pharmacist independent prescribers

Commentary for Q2:

Revalidation: myGPhC technical development was completed on time to allow registrants to make their revalidation submissions. A technical bug was identified after a proportion of the register received reminder communications in error and remedial work was undertaken to fix this issue. Advertisements for revalidation reviewers were launched and a good pool of candidates have made applications. We are continuing to monitor closely sign up and revalidation submission rates in advance of the 31st October renewal deadline. Tailored communications have been sent to the registrants who have yet to sign up (less than 10% of the register now).

Pharmacy technician IET standards: The timetable for accrediting courses based on our 2017 standards is dependent on courses being presented to us for accreditation. We anticipate courses based on the standards will be enrolling trainees in both 2019 and 2020. Our position remains that we will accredit courses as soon as they are available.

Pharmacist independent prescriber ET standards: The consultation analysis report on new standards for the education and training of pharmacist independent prescribers was presented to Council as planned in September. In order to analyse the detailed feedback to the consultation – and to create the necessary capacity to develop the draft pharmacist IET standards consultation in November - the post-analysis redraft of education and training standards for pharmacist independent prescribers has been put back from October to December 2018.

Education and training of non-registered pharmacy staff: Consultation meetings with patients and unregistered pharmacy staff are taking place in October. These meetings will inform revised proposals for the education and training of unregistered pharmacy staff, which will be presented to Council in early 2019.

Pharmacist IET standards: Issuing these standards in late 2018 has been prioritised.

The overall RAG status is green reflecting the fact that whilst the complexity, nature and volume of work remains high, good progress is being made.

Transforming our organisation, our services and processes

Strategic aim: **Pharmacy regulation is efficient and effective**

RAG	Direction of travel
A	

In 2018/19 we will:

- Improve online services to enable registrants to complete and review their revalidation records online
- Improve online services for registration, renewal and application functions in phases throughout the year
- Embed equality, diversity and inclusion (EDI) in both our role as a regulator and employer
- Conduct a survey of our registrants' views of the GPhC's services and communications in order to identify areas for further improvement
- Invest in updating our culture, ways of working and means of holding ourselves to account so that we have the right staff with the right skills and attitudes to adapt to the evolving world of regulation and pharmacy professionals
- Continue to invest in our IT infrastructure and applications by moving to cloud based solutions in order to provide a flexible and robust foundation for future needs
- Align our risk management approach to the ISO31000 standard

What does success look like?

- Registrants can complete and submit their revalidation records online and we can review their records online
- Registrant services are improved with new online services for registration, renewal and application functions
- The GPhC will progress commitments to EDI. For one of our key priority areas, disability, we will have started the implementation of the formal disability standard
- The registrant survey findings inform the baseline against which we measure any improvement in our communications and services
- The culture statement, refreshed values, and behaviours are embedded in every part of the GPhC and used by managers and staff to underpin the Performance Development Review (PDR) process
- IT infrastructure and applications are moved to a cloud based solution
- We can demonstrate how risk has been actively managed to support objectives being achieved

Key links and assumptions

- Revalidation and registrant online services work is being delivered by the same team
- The refreshed values and behaviours will be incorporated into the new way of recruiting which will have a values based focus.
- Objectives will be clearly articulated and success defined at all levels in the organisation
- A member of Senior Leadership Group will act as a risk champion

Main risks

- Capacity and resources to implement change across the different pieces of work that make up this strategic priority
- Effectiveness of senior decision making
- Interdependencies between multiple pieces of work
- Cynicism/frustration at the pace of change

Outline timetable:

April-June 2018	July-September 2018	October-December 2018	January-March 2019
• Revalidation: Launch of myGPhC during April. Registrants start recording their revalidation records • Revalidation: Second phase of revalidation development covering record submission and exceptional circumstances • Development, testing and release of online registration applications for pharmacists • Stabilisation of new Azure infrastructure • Re-setting the culture: Schedule workshop sessions with the heads of function to present the new culture statement and collate their feedback • Re-setting the culture: Agree the refreshed values with SLG and communicate to all employees • Re-setting the culture: Monitor and evaluate if there has been an increase / decrease / stabilising of staff turnover during the period of implementing the cultural re-design • Risk: Strategic risks have been refreshed and mapped against current strategic aims to ensure they represent current objectives	• Revalidation: Testing and release of second phase of revalidation services. Registrants start to submit their revalidation records online from September • Initial scoping for moving SharePoint and infrastructure services to the cloud • Registrant survey: Analyse results of survey and prepare draft report • Re-setting the culture: Carry out research to establish how the cultural element of the GPhC benchmarks against similar sized organisations or an inter-regulatory group within the sector • Risk: Complete internal context which describes how the organisation works • Risk: Develop guidance document to assist coaching of risk owners • Risk: Fully develop register of new strategic risks • Risk: Provide update on ISO work to Council • EDI: Produce a transgender policy to ensure that the GPhC is able to provide access, adjustments and	• Revalidation: Further development of revalidation and registrant online services • Finalisation on approach, to move SharePoint and infrastructure services to the cloud • Phased migration of SharePoint and infrastructure services to the cloud • Registrant survey: Share and discuss key findings internally and identify learnings and actions • Registrant survey: Approve and publish report • Re-setting the culture: Work with the Learning and Development Manager to integrate the mapped culture, values and behaviour framework into the new PDR process • Re-setting the culture: Work with heads of function to support the integration of the mapped culture, values and behaviour information into a value based recruitment process • Risk: Further develop risks that sit below strategic level • Risk: draft strategy and other documents for ISO alignment • EDI: Produce a draft health and wellbeing strategy	• Testing and release of new online services for registrants • Phased migration of SharePoint and infrastructure services to the cloud • Re-setting the culture: March 2019, carry out the third of 4 pulse surveys • Re-setting the culture: Work with the Learning and Development Manager to support the integration and rollout of the new behaviour framework into the new PDR process • Risk: Develop risk appetite statement(s) • Risk: Launch updated framework • EDI: Develop further guidance supporting EIAs to ensure that the 'circle' of impact assessment is completed

• Risk: Function and project level risks reviewed and analysed to enhance understanding of the GPhC risk profile • EDI: Strengthen the GPhC's capability to provide access, adjustments and raise awareness of people with disabilities.	raise awareness of people who are transgender	• EDI: Support the collection and analysis of GPhC EDI data	

Commentary for Q2:

Improve online services to enable registrants to complete and review their revalidation records online
Following the March go live of myGPhC, over 67,250 registrants, (over 80%) have completed the myGPhC sign up process by the end of the Q2 period. The second phase of the development was completed to schedule and released at the end of August to allow registrants to submit their revalidation records to us for the first time from the start of September.

IT infrastructure
During July to September work has been completed on the initial scoping for moving SharePoint and infrastructure services to the cloud. This will allow us to finalise our approach and start to move SharePoint and infrastructure services to the cloud in the next quarter.

Survey of registrants
Work has begun on analysing the results of the survey of registrants' views of our services and communications and preparing the draft report, but due to other commitments the draft has not yet been completed.

Re-setting the culture
The pulse survey was carried out in September and although there was good engagement, there was a slight dip in the percentage of submissions when compared to the pulse survey carried out in May 2018. People Insight, our external providers are preparing the survey analysis, which will be available for dissemination in the Autumn. We have started our research with other regulators to establish how the cultural element of the GPhC benchmarks against similar organisations and the report will be produced by the end of October 2018. The Behavioural Framework has been completed and signed off by the Senior Leadership Group (SLG)

Embed equality, diversity and inclusion (EDI) in both our role as a regulator and employer
We are working with each directorate to understand the needs of EDI in the following areas; current projects, guidance and policy development. We are using this information to ensure that the EDI team can continue to support and share areas of good practice.

We have progressed in building disability confidence with the development of a draft procurement policy and training of the first cohort of mental health first aiders. Agreement has also been reached to develop a joint regulatory disability network.

Risk Management

Practical work linked to managing risk and presenting updates to Council have been completed on schedule. Work to develop a context document for ISO 31000 alignment has been delayed as more resource was needed than anticipated for the assurance review on the Integrity of the Register. We now expect to complete the context description by December 2018, though this will not adversely impact on Q3 deliverables.

Business planning

Work continues on our financial strategy, reviewing our wider regulatory strategy and approach, including making sure this is more grounded in operational reality, and applying the insights from the internal audit reviews on transformation and cost metrics. There are a number of workstreams involved in taking a more holistic approach to our strategy and business planning work. These include:

- Developing a 10-year vision for the type of regulator we want to be
- The 2018/19 budget reforecast and implications for budget deficit
- Laying the last year of our Strategic Plan 2017-20
- Fees consultation for 2019-20
- Developing the Annual Plan for 2019/20
- Budget for 2019/20

Work is underway and continuing on all these workstreams working within a clear strategic framework of themes and priorities. With a view to efficiency and effectiveness, in most cases we are using existing mechanisms where possible to proceed with the work e.g. the planning and budgeting process, as well as bringing relevant decisions to Council. The views of the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG) have also been sought**.**

It is recognised that 2019/20 is a transition year to support our longer-term vision and strategy for the next 10 years. Further updates on this work will be provided at Council, EEAAG and ARC.

The overall RAG status is amber reflecting the stage we are at with some of our areas of work. There are a number of outstanding governance and management issues including action points from cost metrics and transformation audits which are not yet complete and are contingent on the progress of our long-term vision and strategy work.

General Pharmaceutical Council

Management Accounts 30 September 2018

1. At the half year point for the 2018-2019 financial year the organisation shows a **favourable** variance of **£362K** against the "revised budget" including interest and tax**.**

The actual year to date deficit is **£577K** versus a **£939K** revised budget deficit

Actual income is **£11.8M** year to date **(£34K)** below the revised budget

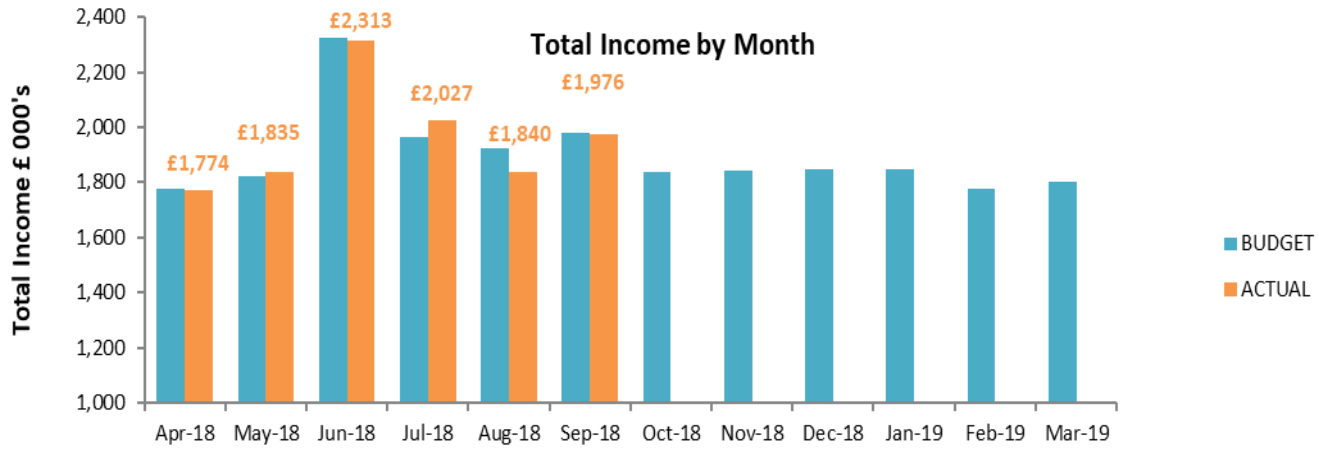
Actual overhead expenditure is **£12.4M, 3.0% (£380K)** below the revised budget

Income *(Please see Appendix 1 for Summary Management Accounts and Appendix 2 for detailed Management Accounts)*

2. The overall organisational income for the year to date is a **£34K (0.3%)** adverse variance against the revised budget. Pharmacists, Premises and Technicians income are broadly in line with the revised budget. This is due to the number of pharmacists on the register being slightly below expectation for this point in the year. Premises income is also behind the revised budget due to a much lower number of 'transfers of ownership' in comparison to the previous years.
   Exam income for the year to date is ahead of the revised budget by **£24K (3.7%)**, which equates approximately 137 candidates.

3. Other income is ahead of the revised budget year to date by **£20K (12.5%)** because a number of accreditation events required extra days. The additional income will be off-set against the costs of the events as the charging model is based on cost recovery.

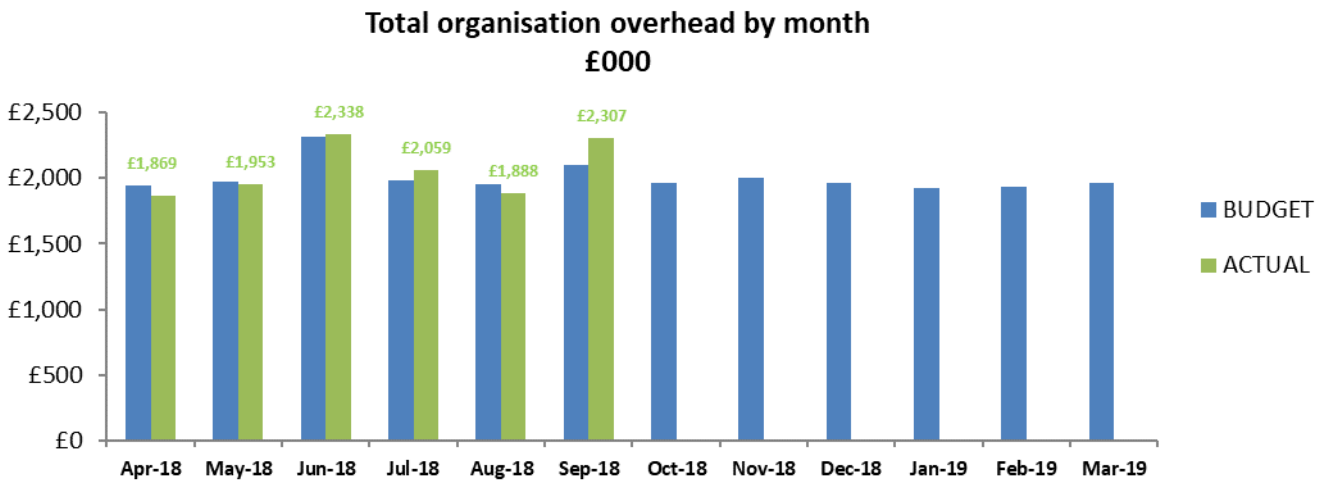
Graph A



Overheads *(See appendix 1 Summary Management Accounts and appendix 2 detailed Management Accounts)*

4. Overall the total years to date expenditure on overheads are behind the revised budget by **£380K (3.0%).**

Graph B



5. **Employee costs: Payroll & Other** for the year to date shows a marginal favourable variance of **£4K (0.1%)** below the revised budget. **Basic salaries** are underspent as there are approximately 13 vacant roles currently undergoing recruitment. Savings made in basic salaries due primarily to vacancies have been offset by increased expenditure on temporary contractors. **Contractors costs** are at present **£165K**, above the revised budget.

6. **Council & Associates costs:** Actual expenditure is **£79K (7.7%)** below the revised budget year to date. **Attendance Fees** are underspent by **£56K (7.5%)**, which relates to a lower than expected number for hearing days than predicted and some of the non-chargeable accreditation events being postponed. **Accommodation** remains underspent by **£29K (27.0%)** due to a reduced number of council/associate members staying overnight.

7. **Office & Property Costs** show a minimal overspend against the year to date revised budget. Increase in postage costs of **£10K** due to Revalidation ID login details for MyGPhC, which had to be posted to all registrants. **Repairs and Maintenance** are also overspent by **£5K** due to unplanned boiler inspections and the replacement of macerators.

8. **Professional Costs** show a favourable variance of **£214K (16.7%)** against the year to date revised budget. **Consultancy** makes up the large proportion of the **£210K (57.2%)** underspend, due to timing delays on several pieces of work. This includes rewards and recognitions review that has commenced and should be completed in December 2018. In addition, Finance Navision (Accounting Software) upgrade has been put on hold until April 2019, website design that has now been postponed to December 2018, and Data & Insight scoping strategy being at design stage. **Professional Fees** are **£39K (22.3%)** overspent year to date. This was partly due to professional advice sought around charitable status, which was not budgeted **(£12K)**. We have also seen a rise in the number of health-related cases. This has led to an increase in the number of medical reports and assessments required as well as clinical advisors for Fitness to Practise hearings.

9. **Research Costs** remains below the year to date revised budget by **£95K**. The underspend relates to the registrants' survey which is due to commence shortly.

10. **Occupancy Costs** are overspent by **£236K (23.0%)** mainly due to an increase in business rates. We are aware that there is likely to be an increase in rates because of the revaluation of property, which had been delayed by government. Therefore, an estimated provision has been made to account. There is some uncertainty around the amount and when it is due to commence. The finance team are liaising with lawyers and CIB properties (Landlord) to obtain an accurate figure, which will be confirmed in a few months.

11. **IT costs** remains below the revised budget year to date at **23.0% (£196K)** due to IT development (New Cloud Project) work being delayed. It is most likely that the project costs will now be capitalised, which is line with the current GPhC processes to assess all development project under FRS 102 criteria.

12. The **Reforecast** process is currently underway and we are engaging with the business to evaluate and analyse budget expectations for the remainder of the financial year. This will give a more up to date prediction of where we will be at the end of the year. This exercise will be complete by the end of October 2018.

The **STATEMENT OF FINANCIAL POSITION** as at **30 September 18,** maintains a strong net position for the organisation.

Data table 1

	30-Sep-18	31 Mar 18
	£000	£000
Fixed assets		
Tangible assets	3,473	3,804
Intangible Assets	535	483
Investments	12,500	12,500
	16,508	**16,787**
Current Assets		
Debtors	2,357	1,737
Bank and Cash	11,675	13,814
	14,032	15,551
Creditors		
Amounts failing due within one year	(14,972)	(15,964)
Net current assets	**(940)**	**(413)**
Total assets less current liabilities	**15,568**	**16,373**
Creditors		
Amounts failing due after more than one year	(2,659)	(2,886)
Provision for liabilities	(1,411)	(1,412)
Total Net assets	**11,496**	**12,075**
Funds employed		
Fixed Asset Reserve	4,008	4,287
General	7,488	7,788
Total funds employed	**11,496**	**12,075**

Number of months expenditure represented by General reserve is:	3.7	4.0

13. **Fixed Assets** total **£16.5M**, of which **£3.4M (21.0%)** relates to Tangible Assets, works carried out to Canada Square office and upgrading laptops for office based workers. Intangible Assets such as Information Technology Development projects (Cloud Strategy, Revalidation, Case Tracker & Registrant Online) equates to **£535K**. Intangible assets are increasing due to expenditure on current projects which are not yet live.

14. **Investments** equate to approximately six months of expenditure **£12.5M (75.7%)** that have been invested in long term deposits with various banks.

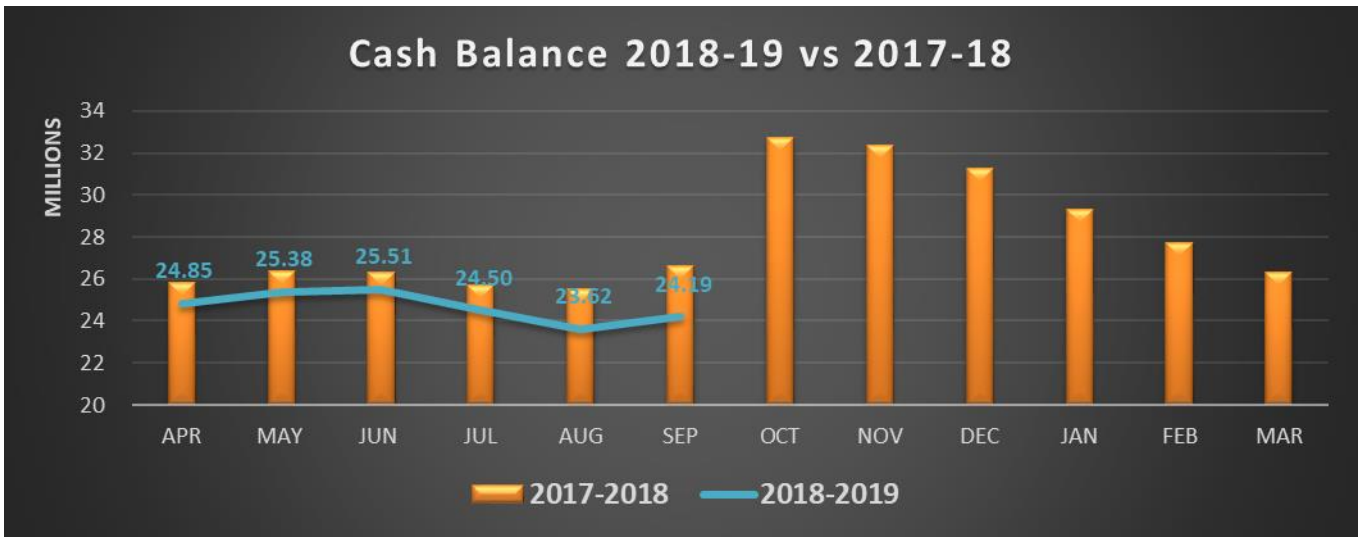
15. **Current Assets £14.0M** includes cash held in bank accounts most of which relates primarily to registrants' income. The debtors' figures include cost recovery for high court appeals as well as prepayments. The high court debtors' balance will be adjusted at the end of each financial year to include a bad debt provision. The prepayment figure includes amounts paid in advance for rent, annual licences and subscriptions.

16. **Current Liabilities** include deferred income in relation to fees paid in advance for all registrant groups, and grant income for the building which will be released over the remaining term of the lease.

17. **Provision for liabilities** include the Landlords contribution to the office fit out which has been offset by the provision for future rent increases. A dilapidation provision has been added this year due to a review of the lease.

Cash Balance

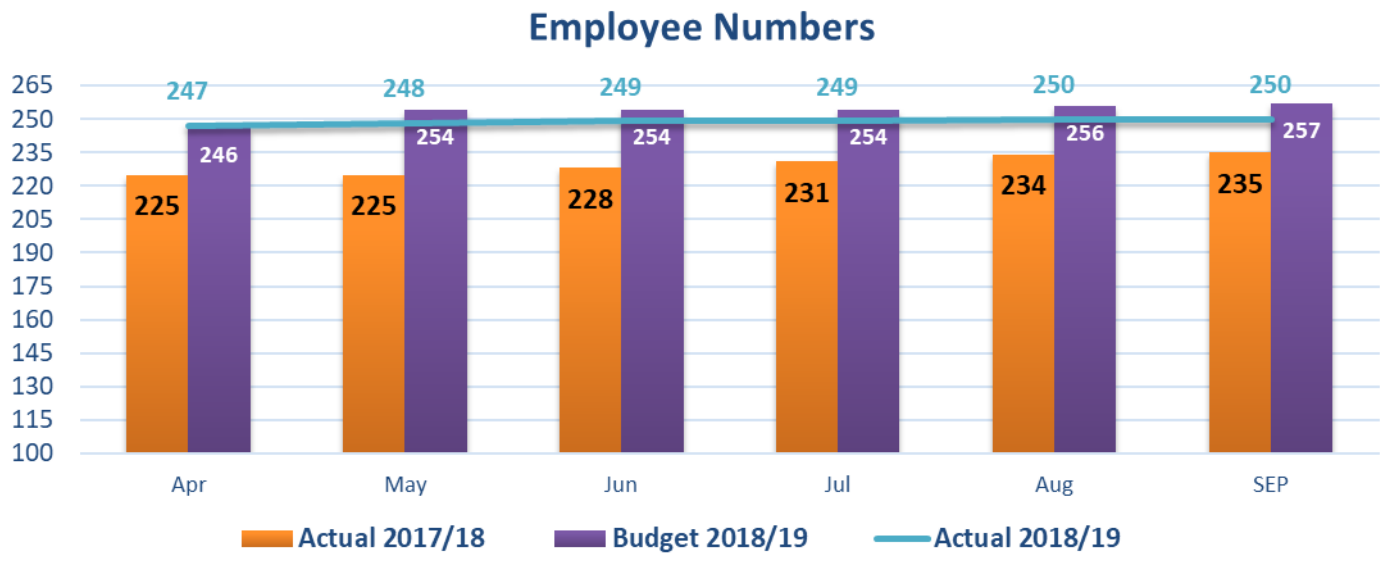
Graph C



18. Over the last **6** months the cash balance has reduced to a lower level than the previous year at this same point in time. This is line with the organisation intention to increase expenditure in order deliver strategic objectives. We are approaching peak renewal and expect cash balance to reach the highest point next month.

Employee Data

Graph D



Data Table 2

Average cost per employee by directorate

Directorate	Average Per Month £	Average Per Year £	Employees
CORPORATE RESOURCES	4,746.13	56,953.58	44
INSIGHT, INTELLIGENCE & INSPECTIONS	5,146.42	61,757.02	54
PEOPLE	4,314.70	51,776.35	31
FITNESS TO PRACTISE	3,655.63	43,867.50	58
EDUCATION & STANDARDS	3,290.12	39,481.44	59
ORGANISATIONAL AVERAGE	4,230.60	50,767.18	250

Summary Management Accounts 30 September 2018

Appendix 1

	Current Month				Year to Date			
	Actual £	Revised Budget £	Variance £	Variance %	Actual £	Revised Budget £	Variance £	Variance %
Total Revenue	**1,975,771**	**1,979,942**	**(4,171)**	**(0.2)**	**11,764,805**	**11,798,498**	**(33,693)**	**(0.3)**
Employee Costs	1,189,617	1,175,054	(14,562)	(1.2)	7,066,866	7,070,536	3,669	0.1
Council & Associate Costs	122,599	134,358	11,759	8.8	930,852	1,009,450	78,598	7.8
Property Cost	18,238	21,816	3,578	16.4	134,417	129,646	(4,771)	(3.7)
Office Costs	53,892	60,827	6,935	11.4	260,133	255,584	(4,549)	(1.8)
Professional Costs	199,182	285,851	86,669	30.3	1,065,475	1,280,369	214,894	16.8
Event Costs	106,681	148,256	41,575	28.0	372,322	416,991	44,669	10.7
Marketing Costs	1,478	15,360	13,882	90.4	49,777	72,774	22,997	31.6
Financial Cost	98,407	94,450	(3,957)	(4.2)	496,291	480,022	(16,269)	(3.4)
Research						95,000	95,000	100.0
IT Cost	104,312	124,574	20,262	16.3	654,702	850,444	195,742	23.0
Other Costs	17,965	17,999	34	0.2	119,801	105,841	(13,960)	(13.2)
Service Level & Occupancy	394,707	171,406	(223,301)	(130.3)	1,263,985	1,028,436	(235,549)	(22.9)
Total Overheads	**2,307,077**	**2,249,951**	**(57,125)**	**(2.5)**	**12,414,623**	**12,795,093**	**380,470**	**3.0**
Interest	16,551	12,000	4,551	37.9	90,020	72,000	18,020	25.0
Tax	3,145	2,400	(745)	(31.0)	17,104	14,400	(2,704)	(18.8)
Net Operating Surplus/(deficit) After Interest and Tax	**-317,899**	**-260,409**	**-57,490**	**22.1**	**-576,902**	**-938,995**	**362,093**	**-38.6**

Meeting paper

Council on Thursday, 08 November 2018

Public business

Consultation on developing our approach to regulating registered pharmacies

Purpose

To provide Council with a report on the feedback from the consultation on proposals for developing our approach to regulating registered pharmacies.

Recommendations

The council is asked to note:

a) the analysis of the responses to our consultation (Appendix 1) and that we will publish this on our website, and

b) the equality impact assessment of the proposals, developed on the basis of what we heard in the consultation (Appendix 2)

1. Introduction

1.1. In the twelve weeks between 17 May and 9 August 2018, we consulted on proposals for developing our approach to regulating registered pharmacies. These were intended to build on the improvements we have made over the past five years and to reiterate our commitment to the dual function of pharmacy regulation, which is to provide assurance and to drive improvement. The approach we proposed was designed to be even more conducive to flexible, agile and responsive regulation.

1.2. We proposed:

a) introducing three types of inspection: routine inspections, intelligence-led inspections and themed inspections

b) moving to unannounced inspections as a general rule

c) changing the overall inspection outcomes to 'standards met' or 'standards not all met', and introducing four possible findings at a principle level - 'standards not all met', 'standards met', 'good practice' and 'excellent practice'.

d) requiring all standards to be met to receive an overall 'standards met' outcome

e) publishing inspection reports, and improvement action plans, when relevant, on a new website

f) sharing examples of notable practice by publishing them in a 'knowledge hub' on the new website

2. Key considerations

The GPhC's strategic objectives

2.1. This consultation is closely aligned with our strategic aims, as per our Strategic plan 2017-20, to ensure that registered pharmacies deliver safe and effective care and services, and that pharmacy regulation is efficient and effective. The consultation proposals are fully in line with our commitment to adapt the way in which we regulate, being truly flexible, proportionate and responsive, and using the best available evidence to support our work.

Consultation, analysis and reporting

2.2. As part of the consultation, we:

a) organised three pre-consultation focus groups with patients

b) spoke to key political stakeholders and attended 22 stakeholder events across the three countries

c) commissioned a YouGov survey of 2040 adults in Great Britain

d) ran a 12-week consultation and received 812 written responses

2.3. Our consultation survey asked questions on:

a) the proposed changes

b) the impact of the changes on pharmacy service users, pharmacy owners, the pharmacy team, as well as on individuals or groups who share any of the protected characteristics

2.4. The full consultation report can be found in Appendix 1.

2.5. We have considered every response received, as well as notes from stakeholder events. Our thematic approach allows us to fairly represent the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events.

Key findings

2.6. We received general support for many of the areas covered in our consultation proposals. However, there were also areas of divergence in opinion.

2.7. In particular, a majority of respondents supported the proposals for:

a) the three types of inspection

b) the move to unannounced inspections as a general rule

c) the changes to inspection outcomes

d) the new website and knowledge hub

2.8. In relation to publication, whilst a majority of respondents supported the publication of inspection reports, we heard more varied views regarding the publication of improvement action plans and the display of inspection outcomes.

2.9. The requirement for pharmacies to meet all standards in order to receive an overall 'standards met' outcome was seen as the most controversial of the proposals.

The three types of inspection

2.10. The majority of respondents agreed with the proposed approach and that it would lead to more agile, targeted and risk-based regulation. They also agreed that the three types of inspection would contribute to greater assurance and would help drive improvements.

We also received some comments regarding a potential increase in the bureaucratic and inspection burden on pharmacies, as well as some suggestions for a robust and transparent process for appraising the quality of information/intelligence submitted to the GPhC, in order to uncover any potential disingenuous concerns or vindictive reporting.

The move to unannounced inspections as a general rule

2.11. The majority of our consultation survey and YouGov survey respondents supported the rationale for unannounced inspections. Comments often reflected the view that pharmacies should provide the highest level of service and be inspection-ready all the time, rather than preparing specifically in advance of an inspection. It was felt that unannounced inspections would eliminate the possibility of last-minute cover-ups and that they had the potential to uncover poor practices (e.g. low staffing levels presenting a patient safety risk).

2.12. A large number of respondents providing free-text comments, however, disagreed with the proposal. Unannounced inspections were seen as unduly disruptive and stressful to the pharmacy team, potentially impacting on patient care and safety. The main issues identified by respondents included: unavailability of key staff or evidence; access to certain premises; exceptionally busy times in pharmacy, and emergencies.

The changes to inspection outcomes

2.13. The majority of respondents to our consultation survey, and of members of the public responding to the YouGov survey, thought that the proposed overall inspection outcomes would make it clear to patients, the public and pharmacy owners that a pharmacy has met or not met the standards. In the comments provided these were often seen as simpler and less controversial compared to the current system.

2.14. However, a majority of respondents providing free-text comments had reservations about the proposal. Many felt that the proposed outcomes were unclear, over-simplified and too black and white, and that they failed to differentiate between minor and major issues. Others were concerned about the wording and/or presentation and the potential consequences of a 'standards not all met' outcome. There were also those who commented that the binary approach failed to account for excellence and thus drive improvement.

2.15. Many respondents expressed a preference for a more graded approach and suggested greater consistency with other regulators – e.g. Care Quality Commission (CQC)/OFSTED. There were also suggestions for a percentage, traffic light, scoring or a star system, or for an intermediate category, such as 'majority of standards met'.

2.16. Respondents to our consultation survey were broadly supportive of the proposed four findings at a principle level. The majority of them felt that these would be conducive to better measurement of performance and would drive improvement, as long as they were clearly defined. There were also some alternative views, including that patients and the public might be confused by the different systems used on a principle and overall level.

The new website and knowledge hub

2.17. The majority of consultation respondents agreed with our proposals for the new website and knowledge hub. There was broad agreement that the sharing of learning and good practice would focus pharmacy teams on achieving standards and would lead to improvements in pharmacy. Many respondents shared the view that the knowledge hub was a good idea for the profession, as it could help combat the isolation of pharmacists.

2.18. A large number of respondents commented that the success of the knowledge hub would depend on whether the information presented there was easily accessible and on how widely and with what intention it was being used.

Publication

Inspection reports

2.19. The majority of respondents to our consultation and of those completing the YouGov poll agreed with the publication of inspection reports. Those who provided comments often welcomed the increased transparency and the consistency with other regulators. Many felt that publication would provide greater assurance and drive improvements in pharmacy.

2.20. A number of respondents providing free-text comments, however, were of the opinion that publication might harm the reputation of pharmacies and undermine the public's trust in pharmacy professionals, thus jeopardising the business. Others commented on the potential for misuse of the information contained in the reports.

2.21. A frequent comment relating to the publication of inspection reports was that the public would not be interested in pharmacy reports and would not be affected by the findings. This was because they tended to choose pharmacies out of convenience, word of mouth, personal experience, or because of the range of services provided. These points were in line with what people indicated as the main factors influencing their choice of pharmacy in response to the YouGov survey, as well as with what we heard from participants in our focus groups.

Improvement action plans

2.22. Opinions in our consultation survey were almost equally split between those who supported and those who opposed this proposal. Members of the public responding to the YouGov survey, however, were clearly in favour of publication. In addition, their responses showed a significantly increased likelihood of visiting a pharmacy that has not met all standards again, when they knew that an improvement action plan was in place.

2.23. The majority of respondents providing free-text comments on this proposal were against publication. They felt that the detail of the improvement plan should be a private matter between the GPhC and the pharmacy concerned. There were also some comments that improvement action plans may contain commercially sensitive information and that this could be misused by competitors.

2.24. A number of respondents, however, supported the publication of improvement action plans, as they thought this would support transparency and aid understanding. This was also seen as a tool to drive improvement, by showcasing the exact things that pharmacies should focus on.

Display of inspection outcomes

2.25. Consultation survey respondents were equally split in their views on whether pharmacy owners should be expected to display their inspection outcomes in the pharmacy. YouGov survey respondents, on the other hand, supported this proposal by a large majority.

2.26. A large number of respondents providing comments felt that the display of inspection outcomes was the right thing to do for the sake of openness and transparency. Many felt that display of inspection outcomes would lead to increased patient safety and greater consistency of experience. Many also welcomed the consistency of this approach with the existing requirements of other regulators, such as the CQC, OFSTED and the Food Standards Agency[1].

[1] Please note that, by law, care providers have to display their CQC ratings. This is also true for Food Standards Agency ratings in Wales and Northern Ireland. Display of the food hygiene rating sticker in England is voluntary, which is also the case for OFSTED ratings.

2.27. A number of respondents, however, were of the view that display should not be mandatory. They feared the implications of displaying a negative outcome and the risk of misuse and false advertising by competitors. Some respondents commented that inspection outcomes were only valid at the point of issue and could thus be misleading, whilst others mentioned the practical complications of outcome display on the premises.

Requiring all standards to be met to receive an overall 'standards met' outcome

2.28. Whilst a majority of respondents to the YouGov survey supported this proposal, the majority of respondents to our consultation survey disagreed with it.

2.29. Many of those who provided free-text comments on the proposal thought that it was unfair to use the same broad brush for those failing one or the majority of the standards. It was felt that this should depend on the nature of the unmet standard and its potential impact on patient safety. There were also a number of suggestions for differentiation between minor and major faults.

2.30. A number of respondents were of the opinion that the pharmacy should be given a chance to improve within a short timeframe before being assigned the rating of 'standards not all met'.

2.31. Many respondents, however, thought that the proposal for assigning a 'standards not all met' outcome when one standard was failed was the right thing to do. They believed that all standards should be met by all pharmacies at all times. This was also seen as an extension of the binary rating system, where standards were, by definition, either met or not all met.

3. Equality and diversity implications

3.1. Our equality impact analysis work has been informed by our qualitative and quantitative analysis of responses to the consultation and the available evidence relating to groups by reference to protected characteristics.

3.2. Our equality impact assessment is being provided to Council in conjunction with the analysis report and is available in Appendix 2.

4. Communications

4.1. The consultation analysis report will be published on our website.

4.2. We will be bringing the final proposals to Council at the meeting in December 2018 for their consideration.

4.3. We expect to begin implementation of the proposals raised in this consultation in the first part of 2019.

5. Resource implications

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

6. Risk implications

6.1. The consultation proposals discussed in the present paper have the potential to support and improve the delivery of safe and effective care in pharmacy. The intentions behind these are closely aligned with our strategic objectives and it is important to make sure that they live up to these.

6.2. Confidence in the proposals and our consultation process could be undermined if full consideration is not given to the responses and views that we have heard. It is also important that we are able to communicate clearly the rationale behind Council's decisions, as this will assist in communicating and explaining our next steps.

7. Monitoring and review

7.1. Once introduced, we will closely monitor and continually review the success of the proposed approach, including the new types and outcomes of inspections, the publication of reports and improvement action plans, as well as the new website and knowledge hub. We will continue with our ongoing support and engagement with the pharmacy sector and all other relevant stakeholders.

Recommendations

The council is asked to note:

a) the analysis of the responses to our consultation (Appendix 1) and that we will publish this on our website, and

b) the equality impact assessment of the proposals, developed on the basis of what we heard in the consultation (Appendix 2)

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30 October 2018

Consultation on developing our approach to regulating registered pharmacies

Analysis report

1. Policy background

1.1. Between May and August 2018, we consulted on proposals for developing our approach to regulating registered pharmacies.

1.2. These proposals build on the improvements we have made over the past five years and account for the ever-changing face of pharmacy – with the introduction of new service models and a greater use of technology.

1.3. We continue to be committed to the dual function of pharmacy regulation, which is to provide assurance and to drive improvement, as expressed in our strategic plan. We also remain committed to our 'outcome-focused' standards and our 'show and tell' inspection approach, introduced in 2013, which allows inspectors to consider all pharmacy services being provided and to involve the whole pharmacy team in the inspection.

1.4. However, we are planning to move away from a 'one size fits all' approach and towards more flexible, agile and responsive regulation.

2. Summary of our proposals

2.1. To achieve the above aims, we are suggesting the following changes to the way we regulate registered pharmacies:

1) **Introducing three types of inspection: routine inspections, intelligence-led inspections and themed inspections**. This would help us become more agile and more responsive to the information we hold and the intelligence we receive.

2) **Moving to unannounced inspections as a general rule.** This would allow us to make sure that inspection outcomes reflect whether the pharmacy is meeting the standards every day.

3) **Changing the inspection outcomes.** We are proposing to replace our current rating system, so that there are two overall inspection outcomes - 'standards met' or 'standards not all met', and four possible findings at a principle level - 'standards not all met', 'standards met', 'good practice' and 'excellent practice'.

4) **Requiring all standards to be met to receive an overall 'standards met' outcome**

5) **Publishing inspection reports.** We are planning to publish inspection reports, and improvement action plans when relevant, on a new website.

6) **Sharing examples of notable practice.** We are planning to publish examples of notable practice that we identify through our inspections in a 'knowledge hub' on the new website, in order to encourage continuous learning and improvement in pharmacy.

2.2. Our consultation asked for views on the above proposals, as well as on their impact on patients and the public, pharmacy owners and the wider pharmacy team.

3. About the consultation

3.1 Overview

3.1.1. The consultation was open for twelve weeks, beginning on 17 May and ending on 9 August 2018. To ensure we heard from as many individuals and organisations as possible:

- We held focus groups with patients and the public to get their views on our planned approach, prior to consultation.
- We met with a number of key political stakeholders across the three countries we regulate.
- We launched an online survey, which was available for individuals and organisations to complete throughout the consultation period. We also received a number of email responses.
- We commissioned a YouGov Omnibus survey, which included questions on the consultation proposals, to hear from members of the public.
- We attended a series of stakeholder events, including Local Pharmaceutical Committee (LPC) meetings across England and a Directors of Pharmacy meeting in Scotland.
- We promoted the consultation through a press release to the pharmacy trade media, via our social media and through our online publication Regulate.

3.2 Patient focus groups

3.2.1. We organised three focus groups with patients and members of the public, which took place in each of the three countries of Great Britain in November/December 2017.

3.2.2. These focus groups provided valuable insights regarding the use of pharmacy services by patients and the public. Participants' feedback allowed us to test our proposals on publication and display and helped shape our thinking prior to the launch of the consultation.

3.3 Stakeholder meetings and events

3.3.1. Over the past six months we met with a number of key political stakeholders across the three countries we regulate and outlined our proposed approach to regulating registered pharmacies. This allowed us to gauge their feedback on our proposals.

3.3.2. In June/July 2018 GPhC inspectors attended 21 LPC events across England and a Directors of Pharmacy meeting in Scotland. They gave a presentation and facilitated a discussion on our consultation proposals, which provided some useful insights from the community pharmacy sector.

3.4 Consultation survey

3.4.1. We received a total of **812** written responses to our consultation. **685** respondents identified themselves as individuals and **127** responded on behalf of an organisation.

3.4.2. **807** respondents completed our consultation survey. The vast majority of these used the online version of the survey, while the remaining respondents submitted their response by email, using the structure of the consultation questionnaire.

3.4.3. Alongside these, we received five responses from individuals and organisations writing more generally about their views.

3.5 YouGov survey

3.5.1. We commissioned YouGov to carry out a survey, exploring the public's views on our consultation proposals, as well as on online pharmacy services, which were the subject of a separate GPhC discussion paper.

3.5.2. YouGov surveyed **2040** adults living in Great Britain[1] in August 2018 and shared the survey results with the GPhC.

4. Our approach to analysis and reporting

4.1. Overview

4.1.1. We have considered every response received, as well as notes from stakeholder meetings and events, in the development of our qualitative analysis of themes and issues raised in the consultation. Our thematic approach allows us to represent fairly the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing, or heard them in meetings or events.

4.1.2. The different routes through which individuals and organisations could contribute to the consultation meant that some duplication was inevitable. For example, some organisations have met with us at one-to-one meetings and events, and have also submitted a written response. Some organisations were also able to mobilise individual members to respond to us directly.

4.1.3. The key element of this consultation was a self-selection survey, which was hosted on the Smart Survey online platform. As with any consultation, we expect that individuals and groups who view themselves as being particularly affected by the proposals, or who have strong views on the subject matter, are more likely to have responded.

4.1.4. For transparency, Appendix 1 provides a list of the organisations that have engaged in the consultation through the online survey, email responses and/or their participation in meetings and events.

4.1.5. The consultation questions are provided in Appendix 2.

4.1.6. Appendix 3 presents some additional tables on questions from the YouGov survey, referenced in the main report.

[1] This sample was representative of the UK population.

4.2. Our approach to qualitative analysis

4.2.1. This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations, email responses and notes from stakeholder meetings and events.

4.2.2. A coding framework was developed to identify different issues and topics in the responses, to identify patterns, as well as the prevalence of ideas, and to help structure our analysis. The framework was built bottom up through an iterative process of identifying what emerged from the data, rather than projecting a framework set prior to the analysis of the data.

4.2.3. The purpose of the analysis was to identify common themes in the responses of those contributing to the consultation, rather than to analyse the differences between specific groups or sub-groups of respondents.

4.2.4. The term 'respondents' used throughout the analysis refers to those who completed the consultation survey and those who took part in stakeholder events. It includes both individuals and organisations.

4.2.5. The YouGov survey did not contain any open-ended questions. It has thus only been captured under our quantitative analysis.

4.3. Our approach to quantitative analysis

4.3.1. The online consultation survey contained a number of quantitative questions, including yes/no questions and impact rating scales. All responses have been collated and analysed including those submitted by email using the consultation document. Those responding by email more generally about their views are captured under the qualitative analysis only.

4.3.2. Responses have been stratified by type of respondent, so as not to give equal weight to individual respondents and organisational ones (potentially representing hundreds of individuals). These have, however, been presented alongside each other in the tables throughout this report, in order to help identify whether there were any substantial differences between these categories of respondents.

4.3.3. The tables contained within this analysis report present the number of respondents selecting different answers in response to questions in the survey. The ordering of relevant questions in the survey has been followed in the analysis.

4.3.4. Results from the YouGov survey have also been taken into account in the analysis of responses. However, the questions in that survey did not encompass all of the consultation proposals and were formulated in a different way to ensure ease of understanding by the target audience – i.e. members of the public. Hence, they have not been reported consistently in the report, but have only been captured under the respective areas where the consultation questions overlapped with questions from the YouGov survey. Some additional questions and the results of these have been included in Appendix 3.

4.3.5. Figures in the report are shown without decimal places and have been rounded to the nearest whole number. This approach means that the percentages reported in the tables do not always add up to 100 per cent. This rounding also results in differences of up to one percentage point in the case of combining two or more response categories. In addition, whenever a figure of less than 0.5 per cent has been reported in the tables, it has been represented as <1 per cent, instead of 0 per cent.

4.4. The consultation survey structure

4.4.1. The consultation survey was structured in such a way that one or more open-ended questions followed each closed question on the consultation proposals. This allowed people to explain their reasoning, provide examples and add further comments.

4.4.2. For ease of reference, we have structured the analysis section of this report in such a way that it reflects the order of the consultation proposals. This has allowed us to present our quantitative and qualitative analysis of the consultation questions alongside each other, whereby the thematic analysis substantiates and gives meaning to the numeric results contained in the tables.

Analysis of consultation responses and engagement activities: what we heard

5. Introducing new types of inspection: what we heard

Table 1. Views on inspections: Breakdown of responses

Do you think the three types of inspection will:	- provide more assurance that pharmacies are meeting our standards?			- enable us to be more agile and responsive to risks or changes in pharmacy or healthcare?			- help to drive improvements through identifying and sharing good practice?		
	N and % individuals	N and % organisations	Total N ind. + org.	N and % individuals	N and % organisations	Total N ind. + org.	N and % individuals	N and % organisations	Total N ind. + org.
Yes	512 (75%)	95 (77%)	**607 (75%)**	481 (70%)	81 (66%)	**562 (70%)**	499 (73%)	88 (72%)	**587 (73%)**
No	119 (17%)	17 (14%)	**136 (17%)**	113 (17%)	17 (14%)	**130 (16%)**	106 (16%)	19 (15%)	**125 (16%)**
Don't know	53 (8%)	11 (9%)	**64 (8%)**	90 (13%)	25 (20%)	**115 (14%)**	79 (12%)	16 (13%)	**95 (12%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**

5.1. As reflected in the figures in Table 1 above, a clear majority of both individuals and organisations (between two-thirds and three quarters) supported our proposals for the three types of inspection and thought that these would:

- provide greater assurance
- allow us to be more agile and responsive to risks or changes
- help drive improvements

5.2. Between a quarter and over a third of respondents to the consultation survey provided open-ended comments to the respective consultation questions on inspections. The majority of these, as well as of the comments provided in stakeholder meetings and events were supportive of the general direction of travel on pharmacy inspections. They welcomed the more targeted nature and risk-based prioritisation of routine inspections.

5.2.1. There were many comments in support of intelligence-led and themed inspections, sharing the view that these would help the GPhC be more responsive to issues as and when they arise. Respondents thought that these would provide greater assurance to the public and others that the regulator listens to and responds to issues and would investigate concerns, where appropriate.

5.2.2. Some also felt that intelligence-led inspections could uncover issues in pharmacy, such as difficult working conditions, and improve the working environment for pharmacy staff, especially if submitting information/intelligence ~~evidence~~ to the GPhC becomes streamlined.

5.2.3. Themed inspections were welcomed for their potential to provide a thorough insight into a particular matter, to uncover common themes and concerns and provide a useful resource for pharmacy to share learning and improve standards of service provision.

5.2.4. There were also some alternative views and suggestions on the new types of inspection. For example, some respondents were worried about the increased burden of GPhC inspections – e.g. a potential increase in the number or duration of inspections.

5.2.5. Some suggested that there needed to be a robust and transparent process for appraising the quality of information/intelligence submitted to the GPhC, in order to uncover any potential disingenuous concerns or vindictive reporting, or potential conflicts of interest. Others questioned the value of themed inspections or the use of the term 'themed inspections'.

5.2.6. We also received some additional comments / suggestions, regarding:

- the need for further clarity on the structure, aim and reporting of themed inspections, as well as on the themes that the GPhC would be inspecting against
- areas to consider during inspections, or as possible themes for themed inspections – e.g. staffing levels, absence rates, prescription direction, patient feedback, etc.
- suggested triggers for inspection – e.g. new superintendent/owner, delivery of complex services, etc.
- an opportunity for pharmacists or organisations, such as NHS England, to suggest themes for inspection
- carrying out 'undercover' inspections

6. Moving to unannounced inspections: what we heard

Table 1 YouGov. Moving to unannounced inspections

The General Pharmaceutical Council (GPhC), the pharmacy regulator for Great Britain, carries out inspections of pharmacies. Pharmacies are currently usually informed that an inspection will take place at some point in the next 4-6 weeks. The GPhC is proposing to make most pharmacy inspections unannounced. By that we mean that pharmacy staff would not be told in advance about the inspection.	**N**	**% of total**

To what extent do you agree or disagree with the following statement? **Moving from announced to unannounced pharmacy inspections will provide the public with more assurance that pharmacies meet standards for safe and effective care**		
Strongly agree	846	41%
Tend to agree	768	38%
Neither agree nor disagree	253	12%
Tend to disagree	32	2%
Strongly disagree	18	1%
Don't know	124	6%
Base: All GB adults	**2040**	**100%**

6.1. As reflected in the table above, members of the public were strongly in favour of the approach. Seventy-nine per cent of respondents to the YouGov survey agreed with this proposal and only two per cent disagreed.[2]

Table 2. Views on the move to unannounced inspections: Breakdown of responses

Do you think that moving from announced to unannounced inspections as a general rule will provide more assurance that pharmacies are meeting our standards every day?	**N and % individuals**	**N and % organisations**	**Total**
Yes	422 (62%)	62 (50%)	**484 (60%)**
No	212 (31%)	49 (40%)	**261 (32%)**
Don't know	50 (7%)	12 (10%)	**62 (8%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

6.2. As reflected in table 2 above, a higher percentage of individual respondents to our consultation survey were in favour of our proposal to introduce unannounced inspections as a general rule, compared to organisations.

[2] Please note that, throughout the report, we have referred to the totals of agree/disagree, support/oppose, clear/not clear from the YouGov survey results. This would mean, for example, that those who 'tend to agree' or 'strongly agree' have been jointly referred to as agreeing.

6.2.1. Between a quarter and a half of respondents to our consultation survey provided free-text comments to the respective consultation questions. Similar issues to those presented below were discussed at the stakeholder meetings and events.

6.2.2. In line with the support captured in table 2 above, many respondents were in favour of the move to unannounced inspections. They thought that pharmacies should be inspection-ready all the time, rather than preparing specifically in advance of an inspection. A commonly expressed view was that visiting pharmacies without prior notice would ensure that GPhC inspectors can see the pharmacy as it operates on a day to day basis, which would eliminate the possibility of any last-minute cover-ups. A lot of respondents shared observations that there was an urge to meet standards whenever an inspection was imminent (e.g. tidying up, employing more staff, completing outstanding tasks), but standards would often slip soon after that.

6.2.3. A large number of respondents agreed that registered pharmacies should provide the highest level of service at any point and that there should be 'no excuses' for poor performance. From their point of view, pharmacies should be meeting standards every day of the year and should have contingency plans in place to account for any eventuality – emergency or staff absence, among others.

6.2.4. Many were also of the view that the public would feel more confident and reassured if inspections reflected the patient experience of using the pharmacy on a daily basis.

6.2.5. A number of respondents, mainly pharmacy professionals, were in favour of unannounced inspection due to their potential to uncover potentially poor practices – e.g. low staffing levels or unfollowed standard operating procedures. They thought that these would give pharmacy owners and superintendents a stronger incentive to meet the standards and make them more accountable for the safety of pharmacy services, which could also be beneficial for the pharmacy team and, ultimately, the public. In addition, a few respondents thought that unannounced inspections might reduce staff anxiety levels, which tended to creep up whenever they knew that an inspection was imminent.

6.2.6. A lot of respondents, however, disagreed with unannounced inspections. These were seen as unfair to pharmacists and giving the impression that they were not trusted to do the right job.

6.2.7. Respondents often said that unannounced inspections would be disruptive and stressful for the pharmacy team, adding to the existing burden in community pharmacy. A common argument was that there might be an emergency or an isolated incident of poor performance on the particular day of the inspection, which might not show the pharmacy in its true light.

6.2.8. Some respondents believed that unannounced inspections would see the pharmacy team unprepared and not knowing what to expect. They explained that members of the pharmacy team were not used to the terminology used by the inspector and tended to use the advance notice of an inspection as an opportunity to prepare for the practicalities, but also for mental and psychological preparation. The issue of preparation was also mentioned with regard to the responsible pharmacist or the owner/superintendent, who might want to prepare the necessary documentation, as well as some questions or topics to discuss with the inspector.

6.2.9. Some respondents were concerned about failing patient care and safety on the day of the inspection, due to the detracted attention of the pharmacy team. Others commented that patient care would not benefit from these changes in the long term, as the pharmacy team would be 'inspection-focused' all the time, rather than focusing on providing person-centred care. There were also those who were sceptical about

the potential of unannounced inspections to prevent poor practice, as those who were breaking the rules would do so regardless.

6.2.10. Some of the consultation respondents disagreed with the approach on the basis of the inconsistency with other regulators, including the Care Quality Commission (CQC), who give advance notice of inspection to regulated premises where an inspection is likely to cause disruption or have safety implications – e.g. GP practices. Some others wanted more evidence to suggest that unannounced inspections would drive up standards, in order to substantiate the reasons behind GPhC's consultation proposal.

6.2.11. There were also a few who perceived the move to unannounced inspections as a regressive step, as this used to be the norm at the time of the GPhC's predecessor. They worried that pharmacies would become too focused on regulatory compliance, rather than on innovation and improvement, which has been the focus of recent GPhC inspections.

6.2.12. A group of respondents shared the view that inspections were pretty much unannounced at present, as the current window of four to six weeks gave little notice of when the inspection would actually take place.

6.2.13. A number of respondents felt that there should not be any routine unannounced inspections. However, they supported unannounced inspections when it came to intelligence-led inspections or when inspectors were responding to specific concerns. Others felt that there should be a mixture of unannounced and announced inspections, in order to ensure that the dual aim of public assurance and driving improvement is achieved. Some respondents suggested the introduction of a different notice period (either shorter or longer), as a compromise between announced and unannounced inspections, so as to eliminate the possibility of last-minute cover-ups, but to allow for some practical and psychological preparation.

6.3. Situations where unannounced inspections are not possible

Table 3. Views on situations where unannounced inspections not possible: Breakdown of responses

We have identified instances when it may not be possible to have an unannounced inspection. Are there any other instances we need to consider?	**N and % individuals**	**N and % organisations**	**Total**
Yes	154 (23%)	45 (37%)	**199 (25%)**
No	190 (28%)	39 (32%)	**229 (28%)**
Don't know	340 (50%)	39 (32%)	**379 (47%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

6.3.1. As reflected in table 3 above, the majority of respondents did not think there were or could not think of any further instances where having unannounced inspection would not be possible. This view was slightly more prevalent among individual respondents, compared to organisations.

6.3.2. Around a quarter of our consultation survey respondents provided free-text comments on this question. A large number of these commented on the potential unavailability of key staff during the inspection (e.g. the owner/superintendent or pharmacy manager), due to holiday, sickness absence, maternity leave or recruitment periods. They believed that a locum working on the day might have limited knowledge of the services provided by the pharmacy or the whereabouts of key documentation. Some suggested considering a follow-up visit with the regular pharmacist or the owner/superintendent, in case they were absent during the inspection and in case there was need for clarification or further evidence.

6.3.3. A number of respondents raised the issue of the unavailability of key evidence, which could be a hindrance during an unannounced inspection. Respondents commented on the missed opportunity for the regular pharmacist to ask questions or to provide valuable evidence to the inspector, to organise and showcase the full range of the pharmacy's working practices and innovations.

6.3.4. Some settings were mentioned as particularly difficult to get access to on an unannounced basis. This included prisons, internet pharmacies with no access to the public, pharmacies located in airports, retail centres or warehouses, pharmacy hubs, etc.

6.3.5. Respondents also indicated other situations, where unannounced inspections might not be possible or could potentially have an adverse impact on patient safety. These included:

- whenever there is not enough staff to cope with the additional demand of the inspection
- exceptionally busy periods in pharmacy, such as Christmas, Boxing Day, Eid
- periods of refit or stock-taking
- pharmacies introducing new systems or services, or changing ownership
- emergencies
- extreme weather conditions
- epidemics/pandemics
- public health campaigns, such as vaccinations
- newly opened pharmacies

6.3.6. There were a few mentions of a disproportionate impact of unannounced inspections on small independents, compared to big multiples.

7. Two overall inspection outcomes: what we heard

Table 2 YouGov. The inspection outcomes

After a pharmacy inspection is carried out, the outcome will be indicated as 'standards met' or 'standards not all met'. **How clear, if at all, do you think this wording is for you to understand? (Please select the option that best applies)**	**N**	**% of total**
Very clear	853	42%

Fairly clear	715	35%
Not very clear	308	15%
Not at all clear	81	4%
Don't know	83	4%
Base: All GB adults	**2040**	**100%**

7.1. As can be seen from the table above, the large majority (77 per cent) of respondents to the YouGov survey, agreed that the wording was clear to understand. Just under 20 per cent held the opposing view.

Table 4. Views on proposed inspection outcomes: Breakdown of responses

We propose having two possible overall outcomes from an inspection - 'standards met' and 'standards not all met'. **Do you think this will make it clear to patients, the public and pharmacy owners that a pharmacy has met, or not met, the standards?**	**N and % individuals**	**N and % organisations**	**Total**
Yes	403 (59%)	64 (52%)	**467 (58%)**
No	224 (33%)	51 (41%)	**275 (34%)**
Don't know	57 (8%)	8 (7%)	**65 (8%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

7.2. As can be seen from table 4 above, the majority of consultation survey respondents thought that the two proposed overall outcomes would make it clear to patients, the public and pharmacy owners that a pharmacy has met or not met the standards. Just over a third of respondents, however, disagreed.

7.2.1. Up to around a half of respondents provided comments on the questions relating to inspection outcomes. Similar themes were captured in discussions held at our stakeholder meetings and events.

7.2.2. Many expressed a view that the suggested inspection outcomes were clearer, simpler and less controversial compared to the current rating system. A number of respondents thought that, by their nature, standards were either met or not met. They felt that all pharmacies must meet all standards at all times.

7.2.3. The majority of respondents providing comments on the proposal, however, commented that the two outcomes were unclear, over-simplified and too black and white. Many respondents felt that patients and the public, as well as the media, would only see the headline and, without context, perceive it as a 'pass'

or ‘fail’ for the pharmacy. This could easily damage the reputation of the pharmacy and jeopardise the business.

7.2.4. A significant issue was that the new binary approach failed to capture the difference between small shortcomings and big failings, meaning that a ‘standards not all met’ outcome would apply to a pharmacy not meeting one standard, as it would in the case of a pharmacy failing all standards. This could be worrying to the public, who might not appreciate the difference and consider the pharmacy as unsafe. Respondents believed that the nature of the standard not met and the potential impact on patient safety had to be taken into account and that there had to be a way of distinguishing between a minor issue and major non-compliance.

7.2.5. A number of respondents commented that there needed to be accompanying information to substantiate the two outcomes. They suggested providing further detail on the specific failings and the reason for these for the public and commissioners to see, as part of the report.

7.2.6. We also heard a small number of comments regarding:

- the binary approach and its perceived inability to account for excellence and thus to drive improvement
- the large number of pharmacies currently rated as ‘satisfactory’ – it was feared that the majority of pharmacies would, at least initially, receive a ‘standards not all met’ outcome, which could potentially have an impact on public trust and/or commissioning decisions

7.2.7. A number of respondents had reservations about the binary approach and suggested a more graded system instead. They thought that the world of pharmacy was far from being black and white, with nothing in between. Many favoured a system in line with the one used by CQC/OFSTED[3], which was more familiar to patients, the public and commissioners, and allowed for greater nuances in the rating of services. There were also suggestions for a percentage, traffic light, scoring or a star system, or for an intermediate category capturing ‘working towards meeting standards’ or ‘majority of standards met’

7.2.8. Commenting on the proposed wording of ‘standards not all met’, some respondents welcomed the move away from the current ‘satisfactory’ rating, which was seen as negative and potentially ambiguous. They were satisfied that the wording of ‘standards not all met’ made it clear that *some* standards had been failed, not necessarily *all* of them.

7.2.9. However, some respondents expressed disagreement with the wording of ‘standards not all met’ and its presentation in the inspection reports. They perceived the outcome’s wording and the red cross used to represent it as very negative and potentially misleading to the public.

7.2.10. There were also some suggestions for an alternative wording, including:

- ‘all standards met’ alongside ‘not all standards met’
- ‘standards all met’ alongside ‘standards not all met’
- ‘requires improvement’ / ‘standards require improvement’

[3] The rating system used by CQC and Ofsted includes four ratings, namely outstanding, good, requires improvement and inadequate.

- ‘one or more standards not met’ / ‘some standards not met’
- ‘all applicable standards met / not met’ (in case not all are applicable to the pharmacy)

8. Four findings at a principle level: what we heard

Table 5. Views on principle-level findings: Breakdown of responses

We propose having four possible findings for each of the principles - ‘standards not all met’, ‘standards met’, ‘good practice’ and ‘excellent practice’. Do you think this will:	**- provide owners, their teams and the GPhC with a way of measuring performance?**			**- continue to drive improvement?**		
	N and % individuals	**N and % organisations**	**Total N ind. + org.**	**N and % individuals**	**N and % organisations**	**Total N ind. + org.**
Yes	509 (74%)	74 (60%)	**583 (72%)**	469 (69%)	70 (57%)	**539 (67%)**
No	111 (16%)	35 (29%)	**146 (18%)**	113 (17%)	35 (29%)	**148 (18%)**
Don’t know	64 (9%)	14 (11%)	**78 (10%)**	102 (15%)	18 (15%)	**120 (15%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**

8.1. As is clear from table 5 above, the majority of respondents agreed that our proposed findings at a principle level would provide a way of measuring performance to owners, pharmacy teams and the GPhC – this was true for around three-quarters of individuals and 60 per cent of organisations.

8.2. The suggestion that these findings would continue to drive improvements in pharmacy received a significant, albeit slightly smaller majority – of just under 70 per cent of individuals and under 60 per cent of organisations.

8.2.1. Over a third of consultation respondents provided free-text comments in relation to the four inspection findings on a principle level.

8.2.2. A number of these respondents thought that, as long as these were transparent and clearly defined, the four findings would help drive improvements in pharmacy. This was because of their ability to show to the pharmacy team where there was room for improvement, as well as recognising and celebrating success. Respondents also commented that a ‘good’ or ‘excellent’ rating was a positive thing, which gave pharmacies something to aspire to, even if such a rating was unattainable by some of them.

8.2.3. There were also some alternative views, including that:

- having the four findings was unnecessary or too complicated and a ‘met’/’not met’ approach should also be applied to the individual principles

- patients and the public might be confused by the different systems used on a principle and overall level
- the potential of the four findings to drive improvement depended on them being matched by the overall outcomes
- it was hard to differentiate between 'good' and 'excellent' and adding one further finding to the two overall outcomes (e.g. 'exceeding standards') would be sufficient
- there was no incentive to improve if 'good' and 'excellent' were unattainable (this concern was based on respondents' experience of the current rating system)
- the proposed four-point rating scale was unbalanced, with three positive and one negative finding (a balanced rating scale – with two positive and two negative findings was seen as more appropriate)

9. Not meeting one standard: what we heard

Table 3 YouGov. Not meeting one standard

As a reminder, after a pharmacy inspection is carried out, the outcome will be indicated as 'standards met' or 'standards not all met'. Currently, pharmacies have to meet 26 standards in total. The GPhC is proposing that a pharmacy must meet all the standards for registered pharmacies to get an overall outcome of 'standards met'. If a pharmacy has not met one standard, this would result in a 'standards not all met' outcome overall. **To what extent do you agree or disagree with the following statement?** **Not meeting one standard should result in the pharmacy receiving an overall outcome of 'standards not all met'**	**N**	**% of total**
Strongly agree	306	15%
Tend to agree	652	32%
Neither agree nor disagree	408	20%
Tend to disagree	430	21%
Strongly disagree	93	5%
Don't know	151	7%
Base: All GB adults	**2040**	**100%**

9.1. Just under a half (47 per cent) of members of the public responding to the YouGov survey agreed that not meeting one standard should lead to a 'standards not all met' outcome. Just over a quarter (26 per cent) of survey respondents, however, disagreed with the proposal.

Table 6. Views on not meeting one standard: Breakdown of responses

Do you think that not meeting one standard should result in the pharmacy receiving an overall outcome of 'standards not all met'?	N and % individuals	N and % organisations	Total
Yes	209 (31%)	33 (27%)	**242 (30%)**
No	405 (59%)	77 (63%)	**482 (60%)**
Don't know	70 (10%)	13 (11%)	**83 (10%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

9.2. Table 6 above shows that a clear majority of around 60 per cent of respondents (across individuals and organisations) were against the proposal that not meeting one standard should translate in a 'standards not all met' outcome. Less than a third of respondents were in favour of this proposal.

9.2.1. Over a half of our consultation survey respondents provided free-text comments in response to this question. As reflected in point 7.2.4 above, a large number of them felt that it was unfair to use the same broad brush for those failing one or the majority of the standards. Many thought that this should depend on the nature of the unmet standard and its potential impact on patient safety. There were also a number of suggestions for differentiation between minor and major faults, especially given that certain failings were easily rectifiable.

9.2.2. A number of respondents were also of the opinion that the pharmacy should be given a chance to improve within a short timeframe before being assigned the rating of 'standards not all met'. This view was often accompanied by an explanation that this should mainly be the case if only one standard was failed, or if there were minor issues with compliance.

9.2.3. Several respondents suggested that the threshold for receiving a 'standards not all met' outcome should be higher – i.e. that more than one standard would need to be failed, in order to receive such an outcome. There were also several suggestions for the addition of an intermediate category of 'standards partially met' or similar.

9.2.4. Many respondents, however, thought that the proposal for assigning a 'standards not all met' outcome when one standard was failed was the right thing to do. They believed that standards were there to be met and that all pharmacies should meet all standards at all times. This was to ensure the provision of safe, effective and high-quality patient care. Respondents often saw the proposal as a natural extension of the binary rating system, where standards were, by definition, either met or not all met.

9.2.5. Some respondents believed that this approach would provide further assurance to patients and the public and enhance public trust in pharmacy.

10. Publishing inspection reports: what we heard

Table 4 YouGov. Publication of inspection reports

To what extent, if at all, would you support or oppose the following proposals? **Publishing reports from pharmacy inspections on a website for members of the public to access**	**N**	**% of total**
Strongly support	702	34%
Tend to support	859	42%
Neither support nor oppose	299	15%
Tend to oppose	69	3%
Strongly oppose	18	1%
Don't know	93	5%
Base: All GB adults	**2040**	**100%**

10.1. As is clear from the table above, there was overwhelming support for the proposal among members of the public responding to the YouGov survey. Over three quarters (77 per cent) were in favour of publication and only four per cent were against.

Table 7. Views on publication of inspection reports: Breakdown of responses

Do you think we should publish inspection reports?	**N and % individuals**	**N and % organisations**	**Total**
Yes	440 (64%)	81 (66%)	**521 (65%)**
No	158 (23%)	34 (28%)	**192 (24%)**
Don’t know	86 (13%)	8 (7%)	**94 (12%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

10.2. As reflected in table 7 above, around two-thirds of respondents supported the proposal for publishing inspection reports. Around a quarter of respondents were against the move to publish reports.

Table 8. Views on publication of inspection reports: Breakdown of responses

Do you think publishing inspection	**- provide greater transparency about the outcome of an inspection?**	**- provide assurance to users of pharmacy services that pharmacies have met the standards?**	**- enable the pharmacy sector as a whole to use the information in the reports to improve?**

reports will:									
	N and % individuals	N and % organisations	Total N ind. + org.	N and % individuals	N and % organisations	Total N ind. + org.	N and % individuals	N and % organisations	Total N ind. + org.
Yes	471 (69%)	80 (65%)	**551 (68%)**	450 (66%)	76 (62%)	**526 (65%)**	446 (65%)	63 (51%)	**509 (63%)**
No	147 (22%)	32 (26%)	**179 (22%)**	156 (23%)	29 (24%)	**185 (23%)**	149 (22%)	32 (26%)	**181 (22%)**
Don't know	66 (10%)	11 (9%)	**77 (10%)**	78 (11%)	18 (15%)	**96 (12%)**	89 (13%)	28 (23%)	**117 (15%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**

10.3. As is clear from table 8 above, the majority of individuals and organisations believed that publishing inspection reports would provide transparency and assurance to pharmacy service users. On average, around two-thirds of respondents believed this was the case, and around a fifth to a quarter of respondents disagreed.

10.4. The view that publication would allow the pharmacy sector to use the information in reports to improve was supported by a slightly smaller majority of respondents. This was due to the weaker support among organisational respondents, whereby just above half of them agreed and just over a quarter disagreed.

10.4.1. Between a quarter and a half of respondents provided free-text comments to the questions about the publication of inspection reports. The majority of these comments reflected the positive attitude of respondents. It was a widely shared view that publishing inspection reports was the right thing to do, as this would provide transparency, ensure accountability and give the public the opportunity to make informed decisions.

10.4.2. Many welcomed the consistency of this approach with what is already expected of other regulators, such as the Care Quality Commission.

10.4.3. Many also believed that publication would provide reassurance to the public that:

- poor practice is being tackled
- they can trust their pharmacy
- pharmacy services are regulated and inspected, as is the case for other services
- the standards for registered pharmacies are being consistently applied

10.4.4. A number of respondents were of the view that published inspection reports would serve as a source of information for other pharmacies on how to meet the standards. This was expected to allow them to compare themselves with others and to share and identify good practice.

10.4.5. Publication was also seen as a potential driver of improvement and a deterrent to poor practice, as by knowing that the report would be public, pharmacies would strive to meet the standards and improve. Some respondents explained that publication could lead to pride and increased staff morale, as pharmacies would be proud to display their positive inspection results.

10.4.6. A number of respondents, however, were of the opinion that publication might harm the reputation of pharmacies and undermine the public's trust in pharmacy professionals. They believed that it could detract users of pharmacy services from the pharmacy and jeopardise the business. According to some, in addition to the loss of confidence in a specific pharmacy, there might be a negative impact on other pharmacies in the chain, by association, on pharmacies' relations with commissioners, or even on the profession as a whole.

10.4.7. Some respondents commented on the potential for misuse of the information contained in inspection reports and some urged the GPhC to police this to ensure correct and proper use. For example, they mentioned:

- the media sensationalising a story around pharmacy outcomes
- the risk of improper use of the information on social media – e.g. in breach of the General Data Protection Regulation (GDPR)
- the risk of false advertising – e.g. by competitors
- the risk of deliberately using the information to tarnish a particular pharmacy's reputation – e.g. by people wishing to sue the pharmacy
- the risk of abuse of the information by certain groups – e.g. substance misusers interested in weaknesses in a pharmacy's storage of controlled drugs
- the risk of using the information to compile league tables to compare pharmacies, which might not be at all comparable

10.4.8. A frequent comment relating to the publication of inspection reports was that the public would not be interested in pharmacy reports and would not be affected by the findings. This was because they tended to choose pharmacies out of convenience, word of mouth, personal experience, or because of the range of services provided. It was mentioned that patients would be more interested in the patient satisfaction survey results, rather than reports and ratings.

10.4.9. These points were in line with what people indicated as the main factors influencing their choice of pharmacy in response to the YouGov survey. The vast majority of survey respondents (79 per cent) indicated convenience as the main factor. Previous experience, the range of services on offer and a word of mouth recommendation were also stronger influencing factors, compared to the outcome of the pharmacy's last inspection[4].

10.4.10. Our focus groups with patients and the public revealed similar sentiment among participants, the majority of whom believed that personal experience and recommendation would have a greater influence on them compared to reports. The publication of reports was seen as good in itself and was put in the 'good to

[4] See table 7 YouGov in Appendix 3.

know' rather than the 'need to know' bracket. Some of the participants felt that patients unhappy with the service received might be more likely to look for and read the reports.

10.4.11. Some respondents to the consultation survey were of the view that the public would not be able to interpret the results, as they lacked an in-depth understanding of pharmacy. They might thus misinterpret a negative report, or be overly influenced by a 'standards not all met' outcome, which could push them away from the pharmacy of their choice.

10.4.12. We received suggestions for publishing inspection reports not just on the GPhC website, but where patients and the public would look for them and expect to see them – for example on NHS choices or the pharmacy premises/website. This was also in tune with what our focus group participants requested.

10.4.13. A group of respondents were of the view that inspection reports should not be published at all, but should rather be available on request, or should only be available to pharmacy professionals and commissioners, and not to the public.

10.4.14. An alternative view was that inspection reports should be published, but only after they have been anonymised. Not identifying the specific pharmacies in the reports was thought to enable learning, but to avoid the 'naming and shaming' of individual pharmacies.

10.5. Comments on the suggested report templates

10.5.1. As part of the consultation survey, we posed a question asking for opinions on the suggested report templates. Only around one in eight respondents provided comments.

10.5.2. The majority of these suggested that the report templates were clear and helpful. The information on the overall outcome and performance against individual standards was thought to be easy to locate. The availability of the full report for those interested in this was seen as sensible and conducive to transparency. Some held the view that the detailed report was too wordy and complicated and thus only useful to pharmacies as a tool to improve, whilst the summary report was considered more than adequate for patients. We received very similar feedback in our patient focus group discussions.

10.5.3. There were some who disagreed with the wording and presentation – the red cross – of the 'standards not all met' outcome. Respondents believed that this would equate to a poor pharmacy in the eyes of patients and the public, where it might be the case of easily rectifiable issues. Patients and the public participating in our focus groups, however, appreciated the simplicity of the ticks and crosses used in the report templates.

11. Publishing improvement action plans: what we heard

Table 5 YouGov. Publishing improvement action plans

To what extent, if at all, would you support or oppose the following proposals? **Publishing improvement action plans for pharmacies which have not met all standards for members of the public to access**	**N**	**% of total**
Strongly support	614	30%

Tend to support	866	42%
Neither support nor oppose	368	18%
Tend to oppose	64	3%
Strongly oppose	25	1%
Don't know	104	5%
Base: All GB adults	**2040**	**100%**

11.1. As demonstrated in the table above, a large majority of 73 per cent of respondents to the YouGov survey supported the publication of improvement action plans. A small minority of four per cent opposed the move.

Table 9. Views on publication of improvement action plans: Breakdown of responses

Do you think we should publish improvement action plans?	N and % individuals	N and % organisations	Total
Yes	316 (46%)	46 (37%)	**362 (45%)**
No	279 (41%)	61 (50%)	**340 (42%)**
Don't know	89 (13%)	16 (13%)	**105 (13%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

11.2. As is clear from table 9 above, the publication of improvement action plans split the opinions of respondents to the consultation survey. A larger percentage of individuals supported this proposal, compared to organisations. The majority of organisations (exactly half of them) opposed the publication of action plans.

11.3. Over a third of respondents to our consultation survey explained their views on the publication of improvement action plans by providing comments. The majority of these were against the proposal. Respondents believed that the detail of the improvement plan should be a private matter to the pharmacy concerned. Some felt that this would not really be of use to the public. However, many agreed that information on the existence of such a plan should be available for everyone to see.

11.3.1. There were some comments that improvement action plans may contain commercially sensitive information and that this could be misused by competitors. This echoed concerns relating to publication more generally – see 10.4.7 above.

11.4. A number of respondents, however, supported the publication of improvement action plans, as they thought this would support transparency and aid understanding. This was also seen as a tool to drive improvement, by showcasing the exact things that pharmacies should focus on.

11.4.1. Whilst our focus group participants were generally interested to know about the deadline for completion of the action plan and the areas for improvement, some expressed an interest in accessing the detailed improvement action plan.

11.4.2. In addition, having an improvement action plan in place appears to impact on the attitude of members of the public towards visiting a pharmacy which has received a 'standards not all met' outcome. As reflected in tables 8 YouGov and 9 YouGov in Annex 3 of this report, the percentage of YouGov respondents who said they were likely to visit the pharmacy again increased significantly from 45 per cent to 68 per cent on the basis of knowing that the pharmacy was completing an action plan to address its shortcomings.

12. Display of inspection outcomes: what we heard

Table 6 YouGov. Display of inspection outcomes in the pharmacy

To what extent, if at all, would you support or oppose the following proposals? **Asking the pharmacy owner to display the outcomes of the inspection in their pharmacy**	**N**	**% of total**
Strongly support	733	36%
Tend to support	901	44%
Neither support nor oppose	260	13%
Tend to oppose	55	3%
Strongly oppose	19	1%
Don't know	72	4%
Base: All GB adults	**2040**	**100%**

12.1. As reflected in the table above, a vast majority of respondents to the YouGov survey (80 per cent) were in favour of display. Only four per cent opposed the proposal.

Table 10. Views on inspection outcome display: Breakdown of responses

Do you think pharmacy owners should be expected to display the inspection outcome in the pharmacy?	**N and % individuals**	**N and % organisations**	**Total**
Yes	301 (44%)	44 (36%)	**345 (43%)**
No	288 (42%)	60 (49%)	**348 (43%)**
Don't know	95 (14%)	19 (15%)	**114 (14%)**

Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

12.2. As shown in table 10 above, respondents were very much split in their views on the display of inspection outcomes by pharmacy owners.

12.3. A majority of organisations (nearly half of them) opposed the proposal, whereas 36 per cent supported it. This compared with a slight majority of individuals in favour of display (44 per cent in favour and 42 per cent – against).

12.3.1. Over a third of respondents to our consultation survey provided comments in support of their views on display. Similar comments were made in discussions at the stakeholder meetings and events.

12.3.2. A large number of these respondents felt that the display of inspection outcomes was the right thing to do for the sake of openness and transparency. Many welcomed the consistency of this approach with the existing requirements of other regulators, such as the CQC, OFSTED and the Food Standards Agency[5]. They thought the public had the right to know how their pharmacy was performing, so they could make informed decisions. Several respondents mentioned that the display of inspection outcomes in pharmacies ensured increased accessibility, considering those who would not or could not go online to look for the result.

12.3.3. A number of respondents felt that the display of outcomes would lead to increased patient safety and greater consistency of experience, as it would encourage owners of pharmacies to put things right if underperforming. Also, if performing well, pharmacies would be proud to display their rating.

12.3.4. A large number of respondents, however, were of the view that display should not be mandatory but should rather be at the discretion of pharmacy owners, at least until the new system was well embedded and consistently applied. The argument was that this was not necessary if the information could be accessed elsewhere, or if it could be provided on request.

12.3.5. Many believed that owners would be unlikely to display a negative outcome and they should not be expected to do so. It was reiterated that a 'standards not all met' rating would portray the pharmacy in a negative light and could be potentially damaging to the business and the reputation of the pharmacy.

12.3.6. Some respondents commented that inspection outcomes were only valid at the point of issue and provided a mere snapshot in time. They were therefore perceived as potentially misleading, given that the quality of service provision could easily improve or deteriorate in the time between the outcome was displayed and the next inspection of the pharmacy.

12.3.7. Some mentioned the practical complications of outcome display on the premises, given the lack of space and other existing requirements for display – e.g. patient satisfaction survey results.

12.3.8. Once more, there were respondents who doubted the usefulness of this information to patients and the public and some who mentioned the risk of misuse and false advertising by competitors.

[5] Please note that, by law, care providers have to display their CQC ratings. This is also true for Food Standards Agency ratings in Wales and Northern Ireland. Display of the food hygiene rating sticker in England is voluntary, which is also the case for OFSTED ratings.

12.3.9. Patients taking part in our focus groups had an expectation that inspection outcomes should be displayed in the pharmacy. They did recognise that pharmacies meeting the standards would be more likely to display their outcome, but some felt that those failing the standards should be made to display theirs.

13. The website and knowledge hub: what we heard

Table 11. Views on the website and knowledge hub: Breakdown of responses

Do you think the interactive website and knowledge hub will:	**- make information easily accessible?**			**- encourage the sharing of knowledge within the pharmacy sector?**			**- enable learning from examples of standards not being met, and of good and excellent practice?**			**- drive improvements within pharmacy?**		
	N and % individuals	**N and % organisations**	**Total N ind. + org.**	**N and % individuals**	**N and % organisations**	**Total N ind. + org.**	**N and % individuals**	**N and % organisations**	**Total N ind. + org.**	**N and % individuals**	**N and % organisations**	**Total N ind. + org.**
Yes	529 (77%)	100 (81%)	**629 (78%)**	483 (71%)	88 (72%)	**571 (71%)**	532 (78%)	92 (75%)	**624 (77%)**	473 (69%)	82 (67%)	**555 (69%)**
No	59 (9%)	3 (2%)	**62 (8%)**	83 (12%)	7 (6%)	**90 (11%)**	73 (11%)	4 (3%)	**77 (10%)**	86 (13%)	7 (6%)	**93 (12%)**
Don't know	96 (14%)	20 (16%)	**116 (14%)**	118 (17%)	28 (23%)	**146 (18%)**	79 (12%)	27 (22%)	**106 (13%)**	125 (18%)	34 (28%)	**159 (20%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**	**684 (100%)**	**123 (100%)**	**807 (100%)**

13.1. The vast majority of both individuals and organisations – just under 80 per cent – believed that the interactive website and knowledge hub would make information easily accessible. A similarly high percentage of respondents thought that these would enable learning from examples of standards not being met, and of good and excellent practice.

13.2. Just over 70 per cent of both individuals and organisations thought that the website and knowledge hub would encourage the sharing of knowledge within the pharmacy sector. Just under 70 per cent of respondents thought the proposals would drive improvements in pharmacy.

13.3. This positive tone in relation to the proposals was also reflected in the open-ended comments, which we received from over a quarter of respondents. A significant number of them agreed that the sharing of learning and good practice would focus pharmacy teams on achieving standards and lead to improvements in pharmacy.

13.3.1. Many shared the view that the knowledge hub was a good idea for the profession, as it could help combat the isolation of pharmacists. This was seen as especially beneficial for independent pharmacies.

13.3.2. A large number of respondents commented that the success of the knowledge hub would depend on how widely and with what intention it was used. For example, views were expressed that:

- the well-performing pharmacies would use this to become even better, while those struggling to meet the standards would be unlikely to aspire for excellence
- some pharmacies may only infrequently use the resource and only out of curiosity, rather than out of desire to learn and improve
- pharmacy professionals and/or pharmacy owners would not have the time to access and use the hub, and that it would only work effectively if people were to use it
- it was difficult to comment on the hub until it had been put into place and until it was known what the website would look like and how widely it would be used

13.3.3. Many commented that the information on the hub needed to be easily accessible in order to be helpful. This meant, for example:

- being clear, simple and visual, to aid the understanding of patients
- being linked to other information sources – e.g. NHS Choices
- allowing for searches by good and excellent practice
- showcasing how pharmacies could meet the standards
- highlighting innovation and good practice
- well-evidenced and analysed reports of themes and trends, rather than just the inspection reports

13.3.4. Other suggestions included: an email with the highlights for busy pharmacists; adding the functionality of a forum to the hub, so pharmacy professionals can share experience and examples of good practice; using the hub as a whistleblowing channel.

13.3.5. There were some comments suggesting that the reports and examples included in the hub needed to be anonymised, in order to enable learning but prevent identification.

13.3.6. Several respondents commented that the hub might not be useful to the public and that it should only be available to the profession. A few others commented that examples of good and excellent practice might not be equally applicable to different pharmacies.

14. Other general comments

14.1. A frequently raised concern, across all of the consultation questions, was that the proposals would add to the stress and bureaucratic burden of pharmacists. Comments have been made about:

- the multiple demands on pharmacy in times of reduced budgets and corporate pressures
- the lack of staff, time and/or resources to implement the proposals
- the fear of inspection, enhanced by the fear of failure

- the perception that the proposals would have a particularly strong impact on small independent pharmacies, as opposed to multiples

14.2. The need for more clarity or detail was also mentioned throughout the responses and across different consultation questions. Respondents requested more information and/or clarity around:

- the new inspection approach – i.e. commencement; proportion of different inspections (and whether pharmacies can experience more than one inspection in a year); duration of inspections; how inspections would be carried out; how the type of inspection would be determined and announced; more guidance on what is expected of pharmacies and how they can meet the standards; more guidance and support from GPhC inspectors during inspection, as well as to failing pharmacies; GPhC inspectorate capacity
- the new rating system – i.e. robust definitions, objective scoring criteria and a clear decision-making framework
- the publication process and display requirements – i.e. commencement; frequency and timing of uploads; 'life' of published records; retrospective publication; location and required length for display of inspection outcomes
- the process for reviewing reports and the right of appeal – i.e. further detail on appeal arrangements; sufficient time for the owner to review and challenge the report and outcome prior to publication

14.3. Another common theme across the responses was the request for further evidence or greater consistency. In particular respondents wanted:

- greater consistency with other regulators and regulated professions – frequently mentioned with regard to unannounced inspections, ratings and publication
- greater consistency and objectivity of GPhC processes – frequently mentioned with regard to the inspection process and ratings, so as to ensure consistency and lack of bias across GPhC inspectors, as well as ensuring appropriate quality assurance of inspection reports
- more effective use of the GPhC enforcement powers (i.e. having sanctions for non-compliant pharmacies and being able to hold owners to account) – frequently mentioned in the context of large multiples, profit-driven targets, and inadequate staffing levels, and typically brought forward by members of the pharmacy team responding to the consultation survey
- more evidence to substantiate the consultation proposals, or further discussions and trial periods prior to implementation
- more time for determining the impact and effectiveness of the new approach, once it has been applied in practice

14.4. Respondents also frequently commented that pharmacies should be given a chance to improve within a certain limited timeframe, especially in the context of unannounced inspection visits and publication/display of inspection outcomes. A significant number of respondents, across individuals and organisations, were of the view that pharmacies should be given time to rectify their failings before

publication and that the report and grading should be updated promptly afterwards, or only published at that point.

14.5. Another recurring theme in the comments was that the current approach was working well and there was no need to overhaul it completely, where it might be more suitable to adapt and refine it. This was frequently raised in relation to unannounced inspections. Some respondents shared the view that the current inspections were effectively unannounced, given the window of four to six weeks within which an inspection might take place.

15. The impact of the changes: what we heard

15.1. The impact of the changes on service users

Table 12. Impact on people using pharmacy services: Breakdown of responses

What kind of impact do you think the proposals will have on people using pharmacy services?	N and % individuals	N and % organisations	Total
Positive impact	184 (27%)	26 (21%)	**210 (26%)**
Negative impact	54 (8%)	13 (11%)	**67 (8%)**
Both positive and negative impact	325 (48%)	61 (50%)	**386 (48%)**
No impact	86 (13%)	16 (13%)	**102 (13%)**
Don't know	35 (5%)	7 (6%)	**42 (5%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

15.1.1. As can be seen from table 12 above, a majority of respondents (48 per cent), across individuals an organisation, foresaw both a positive and negative impact on users of pharmacy services.

15.1.2. Around a third of our consultation survey respondents provided comments on this question. The majority of them believed that the changes would bring greater awareness and transparency, enable informed choices and provide reassurance that pharmacies are regulated and that action is being taken to address poor practice. Respondents suggested that the proposals might increase the public's confidence and trust in pharmacy and often envisaged improved standards of practice, greater consistency of experience and improved patient safety.

15.1.3. A number of respondents, however, expressed mixed views, in that a positive report might increase public trust and confidence in the profession, but a 'standards not all met' outcome might damage this confidence and cause undue concern.

15.1.4. It was reiterated by a large number of respondents that patients and the public would not really be affected by the proposals, as their choice of pharmacy was mainly guided by convenience and personal experience, and published inspection reports were unlikely to change this.

15.1.5. There were a number of comments about the potential reaction of service users to a negative outcome. It was felt that people might not fully understand the meaning of such outcome, might be confused or worried. Respondents thought that, as a result, they might wrongly assume that the pharmacy is unsafe to use, which would erode their trust. They might also make ill-informed decisions – for example, a 'standards not all met' outcome could discourage people from using a particular pharmacy and encourage a move to a different pharmacy, which might not necessarily be better (or might not provide the same range of services). In the case of patients who might not have a choice of pharmacy (e.g. people in rural communities, detainees, etc.), it might leave them frustrated and unhappy with the pharmacy they use.

15.1.6. Some respondents were of the view that the proposals – especially unannounced inspections and the proposed inspection outcomes – could act as a hindrance to the performance of pharmacies and thus have a potential negative impact on patient care and safety.

15.2. The impact of the changes on pharmacy owners

Table 13. Impact on owners of registered pharmacies: Breakdown of responses

What kind of impact do you think the proposals will have on the owners of registered pharmacies?	N and % individuals	N and % organisations	Total
Positive impact	133 (19%)	20 (16%)	**153 (19%)**
Negative impact	119 (17%)	25 (20%)	**144 (18%)**
Both positive and negative impact	355 (52%)	68 (55%)	**423 (52%)**
No impact	32 (5%)	5 (4%)	**37 (5%)**
Don't know	45 (7%)	5 (4%)	**50 (6%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

15.2.1. As is clear from table 13 above, respondents envisaged both positive and negative impact of the proposals on pharmacy owners. Over a half felt that the impact on them would be mixed.

15.2.2. Around a third of our consultation survey respondents provided comments relating to this question.

15.2.3. It was common for respondents to think that the impact on pharmacy owners would depend on the inspection result and the general leadership style/attitude of the owner. Some commented that the latter would define whether they see the proposals for change as an opportunity or a threat.

15.2.4. Many felt that the proposed approach to inspection, rating and publication would help drive improvements in pharmacy, as it would reinforce good practice and force owners to act whenever their practice was not up to scratch. However, there were also those who envisaged a regulation-focused practice, based on meeting the minimum standards and potentially resulting in greater workload and poorer wellbeing for pharmacy staff.

15.2.5. There was a large number of comments on the added stress, bureaucracy and burden on already overstretched services as a result of the proposed changes. There were, once more, some suggestions of a disproportionate impact of the changes on small independents, as opposed to multiples.

15.2.6. Some respondents believed that owners were unlikely to be impacted by the changes because they were far removed from the day to day running of the pharmacy business.

15.2.7. The opportunity arising from the consultation proposals to hold owners to account and make them more responsible for the service provided was also mentioned by some.

15.3. The impact of the changes on the pharmacy team

Table 14. Impact on the pharmacy team: Breakdown of responses

What kind of impact do you think the proposals will have on the pharmacy team?	N and % individuals	N and % organisations	Total
Positive impact	138 (20%)	18 (15%)	**156 (19%)**
Negative impact	149 (22%)	27 (22%)	**176 (22%)**
Both positive and negative impact	367 (54%)	68 (55%)	**435 (54%)**
No impact	10 (1%)	5 (4%)	**15 (2%)**
Don't know	20 (3%)	5 (4%)	**25 (3%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

15.3.1. As reflected in table 14 above, the majority of individuals and organisations were of the view that the impact of the proposed changes on the pharmacy team would be both positive and negative.

15.3.2. Around a third of respondents provided comments on this question. A large number of them thought that the impact on pharmacies and the team would be determined by their performance. In other words:

- positive inspection results would lead to pride and incentive to continually improve service provision, in addition to willingness to publicise good practice and results, while
- negative inspection results would demoralise and demotivate pharmacy staff and owners, and they would not want their negative inspection results publicised

15.3.3. Whilst many respondents felt that the proposed changes would help drive improvement and have a positive impact on pharmacy staff, a similarly large number of respondents envisaged a more defensive, regulation-focused practise and a negative impact on pharmacy staff.

15.3.4. Those of the former view felt that the proposals would:

- give the pharmacy team clarity on what they needed to achieve and aspire to and would focus them on meeting the standards

- be helpful for owners as a trigger to improve services and hold them to account
- lead to fewer targets and better working conditions, staff development and training for the pharmacy team
- allow the team to learn from other reports and good practice

15.3.5. Those holding the latter view thought that:

- the proposals would add to the bureaucratic burden on struggling pharmacies
- unannounced inspections would add to the stress and anxiety levels of the pharmacy team
- a negative inspection report would be demoralising to the team and potentially damaging to the business
- pharmacies would be under pressure to meet the standards, which might have negative repercussions on the workload and wellbeing of pharmacy staff – e.g. further targets may be imposed on pharmacy staff by pharmacy owners (especially in multiples)
- the pharmacy team would be put under pressure during inspection about things they have little or no control over – e.g. staffing levels, condition of pharmacy, etc.

15.3.6. Some respondents mentioned a potential disproportionate impact of the changes on:

- pharmacy staff who suffer from anxiety – e.g. during unannounced inspections
- vulnerable and older pharmacists – some felt that, with various pressures and due to increasing paperwork, they might be forced to leave the profession
- part-time staff (who are often women), staff who are pregnant or returning from maternity leave – e.g. during inspection, or when they are expected to make improvements following inspection

15.4. The impact of the changes on individuals or groups who share any of the protected characteristics

Table 15. Impact on people with protected characteristics: Breakdown of responses

Do you think anything in the proposed changes would have an impact – positive or negative – on certain individuals or groups who share any of the protected characteristics listed above?	**N and % individuals**	**N and % organisations**	**Total**
Yes	113 (17%)	17 (14%)	**130 (16%)**
No	380 (56%)	75 (61%)	**455 (56%)**
Don't know	191 (28%)	31 (25%)	**222 (28%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

15.4.1. As is clear from table 15 above, the majority of respondents across individuals and organisations did not foresee any negative impact of the proposals on individuals or groups who share any of the protected characteristics.

15.4.2. Only around one in eight of respondents provided comments to support their views on this question.

15.4.3. Some respondents mentioned that the increased transparency and accessibility would have a positive impact on pharmacy service users, some of whom would share any of the protected characteristics – the elderly, people with disabilities and minority groups were specifically mentioned in a few of the comments.

15.4.4. There were, however, multiple comments indicating a potential negative impact on elderly populations or on people with learning or physical disabilities. Respondents felt that these users of pharmacy services might struggle if they had to relocate to another pharmacy due to a poor report and rating (they might not even have a choice of another local pharmacy). Other comments focused on their potential confusion and anxiety when faced with a negative rating, which could lead to a loss of trust in pharmacy, ruined relationship with their local pharmacy team, or medication compliance issues. There were also mentions of these groups' potential inability to benefit from the increased transparency, given that they might be IT-illiterate.

15.4.5. The adverse impact of the additional stress on pharmacy employees suffering from anxiety and other medical conditions, or on disabled or pregnant pharmacy staff was also reiterated by several respondents (see section 15.3.6 above).

15.4.6. There were also single mentions of a potential negative impact on religion and race.

16. Respondent profile

A series of introductory questions sought information on individuals' general location, and in what capacity they were responding to the survey. For pharmacy professionals, further questions were asked to identify whether they were a superintendent or a pharmacy owner. For pharmacy owners we also asked about the size of the business they owned. For organisational respondents, there was a question about the type of organisation that they worked for. The tables below present the breakdown of their responses.

16.1. Category of respondents

Table 16. Responding as an individual or on behalf of an organisation

Are you responding:	**N**	**% of total**
As an individual	684	85%
On behalf of an organisation	123	15%
Total N of responses	**807**	**100%**

16.2. Profile of individual respondents

Table 17. Individual respondents - countries

Where do you live?	**N**	**% of total**
England	570	83%
Scotland	63	9%
Wales	34	5%
Northern Ireland	2	<1%
Other	15	2%
Total N of responses	**684**	**100%**

Table 18. Profile of individual respondents

Are you responding as:	**N**	**% of total**
A pharmacist	556	81%
A pharmacy technician	93	14%
A pharmacy owner who is not registered as a pharmacist or pharmacy technician	0	0%

A member of the pharmacy team who is not registered with the GPhC (eg. a dispenser, delivery driver, a non-registrant pharmacy manager, counter assistant etc)	6	1%
A member of the public	17	2%
Other	12	2%
Total N of responses	**684**	**100%**

Table 19. Superintendent pharmacist: yes/no

Are you a superintendent pharmacist?[6]	**N**	**% of total**
Yes	85	15%
No	471	85%
Total N of responses	**556**	**100%**

Table 20. Pharmacy owner: yes/no

Are you a pharmacy owner?[7]	**N**	**% of total**
Yes	71	11%
No	578	89%
Total N of responses	**649**	**100%**

Table 21. Type of pharmacy owned

Which of the following best describes the pharmacy you own?[8]	**N**	**% of total**
Sole trader	22	32%
Partnership	13	18%
Body corporate	36	50%
Total N of responses	**71**	**100%**

[6] This question was answered by all pharmacists.
[7] This question was answered by all pharmacists and pharmacy technicians.
[8] This question was answered by all pharmacy owners.

Table 22. Working in registered pharmacy

Do you work in a registered pharmacy?[9]	N	% of total
Yes	474	81%
No	110	19%
Total N of responses	**584**	**100%**

Table 23. Main area of work

Please choose the option below which best describes the area you mainly work in:	N	% of total
Community pharmacy	489	73%
Hospital pharmacy	70	10%
Primary care organisation	50	8%
Pharmaceutical industry	9	1%
Research, education or training	15	2%
Other (please specify)	34	5%
Total N of responses	**667**	**100%**

Table 24. Type of community pharmacy

Which of the following best describes the community pharmacy that you own or work in?[10]	N	% of total
An independent pharmacy or pharmacy chain (1-5 pharmacies)	184	38%
A small multiple pharmacy chain (6-20 pharmacies)	54	11%
A large multiple pharmacy chain (21 or more pharmacies)	251	51%
Total N of responses	**489**	**100%**

[9] This question was answered by individuals working in pharmacy.
[10] This question was answered by individuals working in community pharmacy.

16.3. Profile of organisational respondents

Table 25. Responding on behalf of a registered pharmacy

Are you responding on behalf of a registered pharmacy?	N	% of total
Yes	78	63%
No	45	37%
Total N of responses	**123**	**100%**

Table 26. Type of registered pharmacy

Please choose the option below which best describes the pharmacy you represent.[11]	N	% of total
Community pharmacy	63	81%
Hospital pharmacy	8	10%
Pharmacy within a primary care organisation	3	4%
Other (please specify):	4	5%
Total N of responses	**78**	**100%**

Table 27. Organisational respondents: type of organisation

Please choose the option below which best describes your organisation:	N	% of total
Organisation representing patients or the public	7	15%
Organisations representing pharmacy professionals or the pharmacy sector	24	52%
NHS organisation or group	7	17%
Research, education or training organisation	0	0%
Government department or organisation	1	2%
Regulatory body	2	4%
Other (please specify)	4	9%
Total N of responses	**45**	**100%**

[11] This question was answered by everyone representing a registered pharmacy.

Table 28. Type of community pharmacy

Please choose the option below which best describes the community pharmacy you represent.[12]	**N**	**% of total**
An independent pharmacy or pharmacy chain (1-5 pharmacies)	47	75%
A small multiple pharmacy chain (6-20 pharmacies)	4	6%
A large multiple pharmacy chain (21 or more pharmacies)	12	19%
Total N of responses	**63**	**100%**

[12] This question was answered by everyone representing a community pharmacy.

Appendix 1: Organisations

The following organisations engaged in the consultation through either the online survey, email responses and/or stakeholder meetings and events:

Airedale pharmacy

Alexanders pharmacy

Applegate

Association of Independent Multiple Pharmacies (AIM)

Association of Pharmacy Technicians UK (APTUK)

Avicenna Membership Services Ltd

Barnet Enfield and Haringey LPC

Blackwell Pharmacy

BLM Law

Boots UK Ltd

Bristol Community Health

Britannia Pharmacy

Broughton Park Pharmacy Ltd

Buchanhaven Pharmacy Ltd

Care Inspectorate

Care Quality Commission

CD Accountable Officers Network Scotland

County Durham & Darlington LPC

Celesio UK

CG Murray & Son Ltd

Cobrest Ltd t/a H. Lloyd Chemist

Communication Workers Union North West Safety Forum

Community Pharmacy Cheshire and Wirral

Community Pharmacy Humber

Community Pharmacy Lancashire

Community Pharmacy Lincolnshire

Community Pharmacy Scotland

Community Pharmacy Sheffield

Community Pharmacy Surrey & Sussex

Community Pharmacy West Yorkshire

Community Pharmacy Wales

Company Chemists Association

Copmanthorpe Pharmacy ltd

Coventry LPC

Crescent Pharmacy

D. R. Harris

Day Lewis Pharmacy

Department of Health

Derbyshire LPC

Direct pharmacy

Doncaster LPC

Dudley LPC

Easton day night chemist

Elms Pharmacy Ltd

Everetts Pharmacy

Ft taylor pharmacy

G Rowe Services Ltd

G&S Healthcare Ltd

Glemsford Pharmacy

Globe

Gloucestershire LPC

Greater Manchester Local Pharmaceutical Committee

Guild of Healthcare Pharmacists

H.M. Odell Limited

Health Education England

Healthcare at Home

Healthcare Improvement Scotland

Healthwatch Bedford Borough

Healthwatch Bromley

Healthwatch England

Healthwatch Lewisham

Healthwatch Milton Keynes

Healthwatch North Tyneside

Healthwatch Waltham Forest

Healthwatch West Sussex

Hospital Pharmacy Services (Nottingham) Limited

Howells & Jolley

i-dispense

Internet Pharmacy Ltd

Jennings Chemist

Khan Pharmacy

Kingston Hospital NHS Foundation Trust

Kirkmuirhill Pharmacy

Leicestershire Partnership NHS Trust

Leyes Lane Pharmacy ltd

Lincolnshire LPC

Lindsay & Gilmour

Liverpool LPC

Lloyds pharmacy

Long Eaton Healthcare Ltd

M & M Pharmacy

MD & AG Burdon Ltd

Medipharma UK Limited

Meds R Us LTD

Middleway Pharmacy

Murrays Healthcare

My Pharmacy

National Pharmacy Association

NHS Education for Scotland

NHS England

NHS England (Health and Justice commissioning)

NHS England SE KSS

NHS Grampian

NHS Greater Glasgow & Clyde

NHSE Central Midlands

North of Tyne LPC

Northampton General Hospital

Northcare Pharmacies

Northern Devon Healthcare NHS Trust

Northamptonshire LPC

Nottinghamshire LPC

Nuffield Health

Numark Ltd

O'Briens Pharmacies Ltd

PCT Healthcare Limited

PharmaCare Solutions UK Ltd

Pharmacists' Defence Association

Pharmacy Law & Ethics Association

Pharmacy London-Chair, Bexley, Bromley & Greenwich LPC-CEO & Lambeth, Southwark & Lewisham LPC-CEO

PharmaPlus Ltd

Pharmasure Ltd

Polar Speed Distribution Ltd

Prima Pharmacy

Professional Standards Authority

Pharmaceutical Services Negotiating Committee (PSNC)

Rays chemist

Rifaray Pharmacy

Riverside Pharmacy

Rotherham LPC

Rowlands Pharmacy

Royal Pharmaceutical Society

Salmina Ltd

Sandwell LPC

Scottish Government Health and Social Care Directorate

Scottish Independent Advocacy Alliance

Sheffield LPC

Shelf Pharmacy Limited

Shirley Pharmacy Ltd

Silverdale pharmacy

SKF Lo (Chemist) Ltd

South Staffordshire LPC

Spire Health Care Plc

Stepping Hill Healthcare Enterprises Limited

Sudbury Court ltd

Superdrug Stores plc

Swindon and Wiltshire LPC

Tees LPC

Walter Lloyd & Son Pharmacy

Weldricks Pharmacy

Welsh Government

Welsh Pharmaceutical Committee

Whithorn Pharmacy

WISE

www.chemist-4-u.com

York Medical Pharmacy

Appendix 2: Collated consultation questions

In the Introducing new types of inspection, section, we describe the changes we plan to make to the types of inspections we carry out.

1. Do you think the three types of inspection (routine, themed and intelligence-led) will:
    - provide more assurance that pharmacies are meeting our standards?
    - enable us to be more agile and responsive to risks or changes in pharmacy or healthcare?
    - help to drive improvements through identifying and sharing good practice?

    Please indicate 'Yes', 'No' or 'Don't know' to the questions. Please give comments explaining your responses.
2. Do you have any other comments about the types of inspection?

In the Unannounced inspections section, we describe our plans to move from announced to unannounced inspections as a general rule for routine and intelligence-led inspections.

3. Do you think that moving from announced to unannounced inspections as a general rule will provide more assurance that pharmacies are meeting our standards every day?

    Please indicate 'Yes', 'No' or 'Don't know'. Please give comments explaining your response.
4. We have identified instances when it may not be possible to have an unannounced inspection. Are there any other instances we need to consider?

    Please indicate 'Yes', 'No' or 'Don't know'.
5. Please describe the other instances we should consider.
6. Do you have any other comments on us carrying out unannounced inspections as a general rule?

In the Changes to the inspection outcomes section of the consultation document we describe the changes we plan to make to the outcomes of an inspection.

7. We propose having two possible overall outcomes from an inspection - 'standards met' and 'standards not all met'. Do you think this will make it clear to patients, the public and pharmacy owners that a pharmacy has met, or not met, the standards?

    Please indicate 'Yes', 'No' or 'Don't know'. Please give comments explaining your response.
8. We propose having four possible findings for each of the principles - 'standards not all met', 'standards met', 'good practice' and 'excellent practice'.

    Do you think this will:
    - provide owners, their teams and the GPhC with a way of measuring performance?
    - continue to drive improvement?

Please indicate ‘Yes’, ‘No’ or ‘Don’t know’ to the questions.

Please give comments explaining your responses.

Patients have told us that a pharmacy should meet all the standards to receive a ‘standards met’ outcome. This means that not meeting one standard would result in the pharmacy receiving an overall outcome of ‘standards not all met’.

9. Do you think that not meeting one standard should result in the pharmacy receiving an overall outcome of ‘standards not all met’?

   Please indicate ‘Yes’, ‘No’ or ‘Don’t know’.

   Please give comments explaining your response.

10. Do you have any comments about the proposed wording of the overall outcome of an inspection, that is ‘standards met’ or ‘standards not all met’?

11. Do you have any other comments on the changes we are proposing to the outcomes of an inspection?

In the Publication section we describe our plans to publish individual inspection reports for routine and intelligence-led inspections and a composite report for themed inspections.

12. Do you think we should publish inspection reports?

    Please indicate ‘Yes’, ‘No’ or ‘Don’t know’.

    Please give comments explaining your response.

13. Do you think publishing inspection reports will:

    - provide greater transparency about the outcome of an inspection?
    - provide assurance to users of pharmacy services that pharmacies have met the standards?
    - enable the pharmacy sector as a whole to use the information in the reports to improve?

    Please indicate ‘Yes’, ‘No’ or ‘Don’t know’ to the questions.

    Please give comments explaining your responses.

14. Do you have any suggestions about the intended format and content of the summary and detailed inspection reports? You can see samples of the new report templates on our website.

15. Do you think we should publish improvement action plans?

    Please indicate ‘Yes’, ‘No’ or ‘Don’t know’.

    Please give comments explaining your response.

16. Do you think pharmacy owners should be expected to display the inspection outcome in the pharmacy?

Please indicate ‘Yes’, ‘No’ or ‘Don’t know’.

Please give comments explaining your response.

In the Website and knowledge hub section of the consultation document we describe our plans to publish the reports on an interactive website and to introduce a knowledge hub for highlighting and sharing examples of standards not being met and of good and excellent practice.

17. Do you think the interactive website and knowledge hub will:

- make information easily accessible?
- encourage the sharing of knowledge within the pharmacy sector?
- enable learning from examples of standards not being met, and of good and excellent practice?
- drive improvements within pharmacy?

Please indicate ‘Yes’, ‘No’ or ‘Don’t know’ to the questions.

Please give comments explaining your responses.

In the Publishing inspection reports section, we describe the process we will follow when quality assuring and publishing inspection reports.

18. Do you have any comments about the publication process?

Please give comments explaining your response.

Overall questions about these proposals

19. What kind of impact do you think the proposals will people using pharmacy services?

Please indicate ‘positive impact’, ‘negative impact’, ‘both positive and negative impact’, ‘no impact’, or ‘don’t know’.

Please give comments explaining your response.

20. What kind of impact do you think the proposals will have on the owners of registered pharmacies?

Please indicate ‘positive impact’, ‘negative impact’, ‘both positive and negative impact’, ‘no impact’, or ‘don’t know’.

Please give comments explaining your response.

21. What kind of impact do you think the proposals will have on the pharmacy team?

Please indicate ‘positive impact’, ‘negative impact’, ‘both positive and negative impact’, ‘no impact’, or ‘don’t know’.

Please give comments explaining your response.

We want to understand whether our proposals may discriminate against or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010.

These characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

22. Do you think anything in the proposed changes would have an impact – positive or negative – on certain individuals or groups who share any of the protected characteristics listed above?

    Please indicate ‘yes’, ‘no’ or ‘don’t know’.

    Please give comments explaining your response.

23. Do you think there will be any other impact of our proposals which you have not already mentioned?

Appendix 3: YouGov survey[13] – relevant questions and tables

Table 7 YouGov[14]. Factors influencing choice of pharmacy

For the following question, please imagine that you were looking to visit a pharmacy. **Which, if any, of the following factors would have an influence on which pharmacy you decide to visit? (Please select all that apply. If nothing in particular would have an influence on your decision of which pharmacy to visit, please select the 'Not applicable' option)[15]**	**N**	**% of total**
Convenience (i.e. in terms of location/ accessibility)	1616	79%
Whether I have previously had a positive experience with the pharmacy	775	38%
A recommendation from someone I know (e.g. a friend, a family member etc.)	191	9%
The outcome of the last inspection of the pharmacy carried out by the pharmacy regulator	53	3%
The range of products and/ or services offered by the pharmacy	575	28%
Other	70	3%
Don't know	36	2%
Not applicable - Nothing in particular would have an influence on my decision of which pharmacy to visit	196	10%
Base: All GB adults	**2040**	**100%**

Table 8 YouGov. Visiting a 'standards not all met' pharmacy again

For the following question, please imagine your local pharmacy (i.e. the one that you visit most often) had received a 'standards not all met' outcome from an inspection… **How likely, if at all, would you be to visit that pharmacy again?**	**N**	**% of total**

[13] The YouGov survey was commissioned by the GPhC. The fieldwork was undertaken on 8 and 9 August 2018. The YouGov survey also contained other questions, not related to the consultation proposals.
[14] Please note, the table numbers follow the numbering in the present report and do not reflect the question numbers in the YouGov original survey.
[15] Please note, respondents to this question were able to pick more than one answer.

Very likely	198	10%
Fairly likely	720	35%
Not very likely	647	32%
Not at all likely	148	7%
Don't know	327	16%
Base: All GB adults	**2040**	**100%**

Table 9 YouGov. Visiting a 'standards not all met' pharmacy (with an improvement action plan) again

For the following question, please imagine your local pharmacy (i.e. the one that you visit most often) had received a 'standards not all met' outcome from an inspection, but that you were told it was in the process of completing an 'improvement action plan'. An improvement action plan sets out the steps that a pharmacy owner will take to meet the standards that have not been met and includes a date by which the improvements will be made. The inspector from the General Pharmaceutical Council (GPhC) monitors progress and reviews whether the improvements have been made. **How likely, if at all, would you be to visit that pharmacy again?**	**N**	**% of total**
Very likely	367	18%
Fairly likely	1023	50%
Not very likely	341	17%
Not at all likely	50	2%
Don't know	259	13%
Base: All GB adults	**2040**	**100%**

Consultation on developing our approach to regulating registered pharmacies

Analysis of the effects on equality

EA completed by:			
Name:	Ambrose Paschalides, Inspection Operations Manager	**Date:**	19 / 10 / 18
EA approved by:			
Name:	Julian Graville, Head of Inspection (Interim)	**Date:**	19 / 10 / 18

1. Aims and purpose of the project/policy

1.1 This paper analyses the equality and diversity implications of proposed changes to the inspection of registered pharmacies and the publication of inspection reports in order to give effect to the Public Sector Equality Duty under section 149 of the Equality Act 2010. This requires the GPhC to have due regard to each of the statutory objectives, including the need to:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.2 Conducting an analysis of the equality and diversity implications of our proposals also helps to ensure that we are not acting in a way that is incompatible with a Convention right[1].

1.3 Assessing the equality, diversity and inclusion impact of our policy development work is about being proactive in facilitating opportunities for people with the widest possible range of experiences and perspectives to engage with and influence our values, our culture, our strategy and the work we do.

[1]The Human Rights Act 1998, Section 6

We aim to take an inclusive approach to working with users of pharmacy services, registrants, stakeholders and people affected in any way by our policy decisions.

1.4 This EIA includes an overview of the work we have completed to inform our understanding of the equality and diversity dimensions of the proposed changes; and, to consider the potential impact on these groups. This has been informed by our quantitative and qualitative analysis of responses to the consultation; the available data and / or evidence relating to, and our engagement with, a wide variety of stakeholders.

1.5 We have updated the analysis throughout the different stages of the policy development process, including pre-consultation, during the consultation and engagement period and post-consultation.

1.6 The analysis is intended to assist Council in considering whether the changes to the regulatory framework and approach to regulating pharmacies and our proposals should be approved.

1.7 At all stages of the process, we have considered how best to engage with equality groups, and equality and diversity issues have informed our policy development plans from the outset. We have sought to identify and mitigate any adverse impact on pharmacy owners, pharmacy professionals and people using pharmacy services, as well as groups of people with a protected characteristic. We have also considered how the proposed changes can help make a positive impact on these groups.

1.8 In preparing this analysis, we have considered all the statutory objectives under Section 149 of the Equality Act.

1.9 Additionally, given that these proposals have a potential impact on registered pharmacies and how they operate as businesses, we have also included an annex to this analysis examining the regulatory impact of the proposals on this occasion. Information from the impact assessment carried out by the Department of Health (DH) in 2015 for the Rebalancing medicines legislation and pharmacy regulation programme: Registered pharmacy standards and related matters[2] and the DH's Report on responses to the consultation[3] in 2016 has been included here, as well as information from the specific questions in the formal consultation about the regulatory impact of our proposals.

Policy context

1.10 As the regulatory body for pharmacy one of the roles of the GPhC is to assure the public that registered pharmacies are safe to provide services. One of the ways that the GPhC does this is to use its Inspectorate. The GPhC has a team of Inspectors who visit registered pharmacies to make checks on them to make sure that they are meeting the standards for registered pharmacies that the GPhC sets.

1.11 Standards set by the previous pharmacy regulator were prescriptive and inspection at that time, before 2010, focussed on compliance with those prescriptive standards and the legal requirements around controlled drugs and other relevant legal provisions.

1.12 In 2010, the GPhC began by adopting many of the standards from the previous regulator as a transitionary measure. In 2012, after a period of extensive engagement and consultation the GPhC

2 **Impact assessment: Rebalancing medicines legislation and pharmacy regulation programme: Registered pharmacy standards and related matters**
3 **Report on responses to the public consultation on the Pharmacy (Premises Standards, Information Obligations etc.) Order 2016**

developed and adopted new outcome focussed standards for registered pharmacies[4]. The formal consultation ran from February to May of 2012. And the final version of the standards came into effect in September 2012.

1.13 To inspect pharmacies against the new standards, a new prototype inspection model was developed. The new inspection model was introduced in November 2013. This new model used a new framework and approach of "show and tell" to cover all the pharmacy's services, involve the whole pharmacy team and promote professionalism by encouraging the exercising of professional judgement to meet the standards.

1.14 The GPhC published an update paper in February 2015 to restate its core principles in this area of regulation, and to commit to update the new model on the basis of feedback received and the evidence available.

1.15 The GPhC commissioned independent research[5] to evaluate the new approach to regulating pharmacies. The findings were published in a report in October 2015. The research said that the new approach was generally working well, and highlighted some areas that could be improved.

1.16 Following changes to the law in May 2018 the GPhC was given new powers. These included new powers of enforcement and the ability to publish inspection reports. In light of these changes we set out our six proposals on how we intend to modify our approach to the regulation and inspection of registered pharmacies in a consultation document, and sought views on what we propose to do. We also carried out pre-engagement with patient focus groups and held several round table meetings with other stakeholders and commissioned a survey of the public.

1.17 Inspection outcomes - One of the elements of the new inspection model introduced in 2013 was a system of ratings for each pharmacy to indicate how it performed against the 26 standards. An overall judgement of either poor, satisfactory, good or excellent was assigned to each pharmacy after being inspected. The introduction of this rating system was to promote and drive improvement by introducing a scale of performance which pharmacy owners could continuously improve on and sustain.

1.18 This system of ratings was one of the areas highlighted by the research commissioned in 2015 that could be improved. The rating system was an area that many internal and external stakeholders involved with inspection had provided feedback on, and agreed would benefit from some clarification.

1.19 Following on from this research and feedback from inspectors and pharmacy owners and superintendents who have had their registered pharmacies inspected, we have proposed to make some changes to the way in which pharmacies are rated. We propose to no longer have 4 categories to rate the pharmacy overall. There will only be two possible overall outcomes of the inspection. The pharmacy will either be "standards met" or "standards not all met".

1.20 Sharing examples of notable practice - The standards for registered pharmacies are grouped under 5 principles which broadly cover the areas of governance, staff, premises, pharmacy services and equipment and facilities. We propose to differentiate the performance of pharmacies at an inspection at principle level to identify notable practice. The findings for each principle will be one of four options: "standards not all met", "standards met", "good practice" or "excellent practice". Areas of

[4] **Standards for registered pharmacies**
[5] **Evaluating the GPhC's approach to regulating community pharmacies Final Report to the General Pharmaceutical Council ICF Consulting Services**

notable practice will be highlighted and available in a knowledge hub that will be searchable by anyone, the public and the pharmacy sector alike. This proposal is aimed at driving improvement by sharing good practice and making learning easily accessible.

1.21 Moving to unannounced inspections - Currently advanced notice is given that an inspection will be carried out at a registered pharmacy in the following 4-6 weeks after the notice is given. The GPhC is proposing to change this and make inspection visits unannounced. The public have indicated that this is what they prefer and how they expect inspections to be carried out. It gives a closer representation of how the public experiences that pharmacy on any given day and will more closely reflect whether the pharmacy is meeting the standards every day.

1.22 Requiring all standards to be met to receive an overall "standards met" outcome - Another change is that if any standard is found not to be met the pharmacy overall will also be "standards not all met". Under the current model a standard could be "not met" and may still be judged as "satisfactory" overall. Patients expect that if a pharmacy receives a "standards met" outcome that they will have met all of the standards. The current standards have been in place for over 5 years now and pharmacy owners and pharmacy staff should now be familiar with the standards and what is expected to meet them.

1.23 New types of inspection - We propose to improve our approach to inspections to make sure that we are agile and responsive. We propose to use three types of inspection which we can use in different situations – routine, themed and intelligence led. This will enable us to be more responsive when we need to be and to look at specific issues in pharmacy and services in greater detail, whilst still providing the necessary assurance to the public that we will still routinely inspect every registered pharmacy.

1.24 Publishing inspection reports - We now have the power to publish inspection reports. We have previously stated that we would publish reports once we had the power to do so and the intention is that we start doing this in the first part of 2019. The 2015 research said that publishing reports would help pharmacy owners to improve services and empower patients and the public and the pharmacy sector. The Department of Health in its Impact Assessment said that the publication of reports is a key driver both to improve public confidence and public choice and to reward good performance and highlight poor performance, without imposing costs. The DH also said that by publishing reports it would mean that consumer expectations would be met in more familiar ways to them. The DH views are based upon the experiences of another regulator publishing their inspection reports (the Care Quality Commission – CQC).

1.25 We consulted on our proposed changes to the way in which we regulate registered pharmacies and the publication of inspection reports between 17 May 2018 and 9 August 2018. We then analysed the consultation responses, and incorporated any changes to our approach and proposals.

1.26 Our Council will consider the analysis, updated approach and proposals in November 2018 and if it approves them, then the proposals and the publication of reports will come into effect in the first part of 2019.

1.27 If approved, the proposals, which are set out in the consultation analysis report in detail, will allow the GPhC to:

- modify the way it regulates registered pharmacies in the future, (by using different types of inspection - routine, themed and intelligence led)

- publish inspection reports
- be more open and transparent to the public and the wider pharmacy sector about inspections, and
- share the learning gathered from inspections more widely amongst the pharmacy sector and others through the knowledge hub (and through the publishing of reports).

1.28 Approval of the proposals will mean that our approach to regulating registered pharmacies will continue to provide assurance to the public that pharmacies are safe to provide services and will encourage pharmacy owners to reflect on the services they provide, and the way they operate their pharmacies, and make improvements.

1.29 In carrying out this analysis, we have considered the potential equality and diversity implications of the new proposed regulatory framework and the new process of publishing inspection reports.

2. Review of available information and/or data

Developing our evidence-base

2.1 We have carried out a systematic and evidence-based approach to our policy development, including our assessment and understanding of the equality and diversity dimensions of our proposals.

2.2 We used the research from an independent evaluation (see paragraph 1.15 above) of our approach to inspections to inform our proposals. The research involved analysing 5,350 responses to an online census of the experiences of community pharmacists and pharmacy technicians to the new inspection model. There were also (20) qualitative semi-structured interviews with GPhC inspectors and stakeholder organisations about particular aspects of inspections and to unpack individual responses to the online questionnaire and explore in depth the issues of relevance to the study. Existing research and information was also gathered and reviewed at that time by the research organisation. The research can be seen in full at the link found via paragraph 1.15 above, in the footnote for this paragraph.

2.3 We used feedback from patient focus groups held in England, Scotland and Wales at the end of 2017 to inform the development of our proposals, with respect to the information that the public would want to have access to, and how they would like the information about inspection reports and the inspection outcome to be presented, and made available, to them.

2.4 The key findings at the focus groups were that there was strong agreement that the inspection report (both the summary version and the detailed version) should be publicly available. There was broad agreement that the reports need to be easily accessible and searchable online using a number of options (postcode, pharmacy name, type of pharmacy etc.). The overall outcomes of met and not met were said to be clear and simple to understand. The draft reports were found to be clear, easy to read and contained the information they would expect. Comments were made on the necessity of the notable practice section to be in the summary report, and therefore we moved this section to the detailed report instead. The focus groups were positive about the format, content and tone of the draft reports and broadly understood the need to identify variations in performance at principle level to support improvement. They thought that the descriptions of the four possible options of how well a pharmacy had done under each principle was clear and easy to understand.

2.5 We used data from our quality assurance procedures, including information from our feedback surveys submitted by pharmacy owners and members of the pharmacy team about the inspection process, to make improvements to the current inspection model.

2.6 We have taken into account the feedback from round table events with stakeholders as well as other regular meetings with stakeholders and events throughout 2017 and 2018.

2.7 We have also used the data we gathered through our online consultation. We asked several questions about the potential impact of our proposals on several different groups: pharmacy service users; pharmacy owners; the pharmacy team; and those with protected characteristics.

2.8 The key findings from the formal consultation with respect to the impact of the proposals were that the majority of respondents thought that the changes would have both positive and negative impacts on the different groups asked about. With respect to groups with protected characteristics the majority of respondents thought that there would be no impact on any of these groups or individuals within these groups. Some respondents indicated that there may be impact on groups that may not have access to online resources, or are not fully IT literate. They highlighted that this may include some older people. And similarly accessing written reports online was highlighted as a potential difficulty for people with learning difficulties, language or literacy challenges.

2.9 There were some comments about the potential negative impact on the pharmacy team as a result of the publication of poor inspection results, in particular where members of the pharmacy team were pregnant or were disabled due or had a mental health condition, and whether this may cause additional pressure.

2.10 Several respondents thought that these proposals would have a positive impact on everyone using pharmacies, including those with protected characteristics, as it would encourage improvement in services, openness and transparency.

2.11 The key findings from the YouGov survey of 2,040 members of the public, which were broadly about our proposals generally, were that around three quarters of adults asked thought that moving to unannounced inspections would provide the public with more assurance, (79 per cent); that the wording ‘‘standards met’’ and ‘‘standards not all met’’ is clear, (77 per cent); were supportive of the publication of inspection reports, (77 per cent); supportive of the publication of improvement action plans, (73 per cent); and the display of the outcome of the inspection in the pharmacy, (80 per cent).

2.12 Other findings from the YouGov survey were that the biggest factor in people deciding which pharmacy to use was convenience, (79 per cent). Only 3 per cent of people asked said that the outcome of the last inspection would influence their choice of which pharmacy to use. 45 per cent of adults said that they would be likely to visit a pharmacy that had a ‘‘standards not all met’’ outcome, whilst 39 per cent said they would not be likely to do so. However, when told about the improvement action plan those proportions changed. Knowing that an improvement action plan would be in place where a pharmacy had a ‘‘standards not all met’’ outcome 68 per cent of people said that they would be likely to visit that pharmacy again and 19 per cent of people said that they would be likely to do so. 47 per cent of people agreed that where one standard was not met that should result in an overall outcome of ‘‘standards not all met’’. 26 per cent of people disagreed with that and 27 per cent of people neither agreed or disagreed or didn’t know.

Legal framework

2.13 In developing our proposals we gave due regard to our statutory objectives under Section 149 of the Equality Act 2010 and we believe that the proposals align with our over-arching objective which is the protection of the public[6].

2.14 Our proposals about the publishing of inspection reports are provided for under the Medicines Act 1968, the Pharmacy Order 2010[7], the Pharmacy (Premises Standards, Information Obligations, etc.) Order 2016[8] and the associated commencement Order of Council 2018[9]. We believe our proposals are in line with what the legislation intends and allows us to do.

2.15 Overall, we believe that the proposals are reasonable, fair and justified as good and beneficial for both pharmacy owners and the quality of service that pharmacy users will receive.

3. Screening for relevance to equality and diversity issues	
Does this project/policy have any relevance to (delete as appropriate)	
Age	Yes
Disability	Yes
Gender reassignment	No
Marriage and civil partnership	No
Pregnancy and maternity	Yes
Race	No
Religion or belief	No
Sex	Yes
Sexual orientation	No
Welsh language scheme	Yes
Full EIA	**Yes**

[6] The Pharmacy Order 2010, Article 6(1)
[7] The Pharmacy Order 2010, Article 9(3)
[8] **The Pharmacy (Premises Standards, Information Obligations, etc.) Order 2016**
[9] **The Pharmacy (Premises Standards, Information Obligations, etc.) Order 2016 (Commencement) (England, Wales and Scotland) Order of Council 2018**

4. From the answers supplied, decide what further work needs to be undertaken if the proposals impacts upon diversity or equality issues

4.1 Yes, full EIA required.

4.2 We marked Yes/No to categories in the screening table where we believe there may be impacts on those with protected characteristics.

4.3 If approved, the proposed changes to the new regulatory framework and approach will apply to all registered pharmacies, and will affect all pharmacy owners, those pharmacy professionals working in registered pharmacies, (the majority of registered pharmacy professionals) and will also have impacts on the public using pharmacies and pharmacy services.

4.4 The potential impact of these changes, from an equality and diversity perspective, has been included in the full impact assessment in Section 8 below.

5. Consultation / Involvement

5.1 We used a wide range of communication activities to maximise participation in the consultation across a diverse range of stakeholder groups, as well as general and targeted engagement approaches to reach all potential audiences. Below is a summary of our extensive consultation and engagement activity:

a. We commissioned patient focus groups at the end of 2017 (which were broadly population representative and included people with protected characteristics under the Equality Act 2010) to discuss our proposals. Focus groups were convened in England, Scotland and Wales to ensure that we heard views from across the different nations about the publishing of inspection reports, and the format and content of the inspection reports. We used the feedback to inform and develop the draft inspection report format.
b. At the Inspectors' meeting in April 2018 there were sessions dedicated to the proposed changes and an opportunity to discuss the practical implications of some of the proposals.
c. Consultation was launched via a press release[10] on 17 May 2018.
d. Emails to all registrants, superintendents, owners, pharmacy organisations and professional bodies, Clinical Commissioning Groups (CCGs), health professionals and systems regulators, and patient organisations with a link to the online survey, concurrent with the launch (potential respondents were invited to respond via an online survey, by email or by post). Hard copy, large font and other language versions of the document were available on request.
e. Article in the GPhC online publication 'Regulate'.
f. Provision of a consultation 'tool kit'[11] with a newsletter, powerpoint presentation with speaking notes, and pre-written twitter posts to help stakeholders promote the consultation through their networks

[10] Press release: **GPhC consults on proposals to develop approach to regulating registered pharmacies**
[11] Registered pharmacies consultation tool kit: Registered pharmacies consultation toolkit - newsletter copy ;Registered pharmacies consultation toolkit - presentation ; Registered pharmacies consultation toolkit - speaking notes for toolkit presentation ; Registered pharmacies consultation toolkit - social media guide

g. Follow up emails to registrants and stakeholders on 24 July and 6 August 2018 as a reminder to respond to the online consultation.
h. Members of staff on hand to answer any questions throughout the consultation process
i. Round table consultation events with stakeholders were held in London, Cardiff and Glasgow in June 2018.
j. We commissioned a YouGov survey of 2,040 members of the public representative of the UK population, in August 2018, to ask their opinions on the proposals we had put forward in the consultation around unannounced inspections, the changes to the overall outcome of inspections, publication and the likelihood of them visiting a pharmacy and what informs their decisions on which pharmacy to use.
k. Inspectors gave 22 presentations to stakeholders at Local Practice Committee (LPC) meetings.
l. 1-2-1 meetings were held with:
Association of Independent Multiple Pharmacies (AIM)
Association of Pharmacy Technicians UK (APTUK)
Avicenna
Care Quality Commission (CQC)
Community Pharmacy Scotland
Community Pharmacy Wales
Company Chemists' Association (CCA)
Department of Health and Social Care (DHSC)
NHS England
National Pharmacy Association (NPA)
Numark
Pharmacists' Defence Association (PDA)
Pharmaceutical Services Negotiating Committee (PSNC)
Professional Standards Authority for Health and Social Care (PSA)
Royal Pharmaceutical Society (RPS)
Scottish Government Health and Social Care Directorate
Welsh Government
m. Multiple trade and national press articles relating to the consultation.

Patient focus groups

5.2 As described above, we held focus groups in London, Cardiff and Edinburgh, which allowed us to discuss the proposals in depth with patients and the public. Feedback gathered through these groups, who were broadly representative of the British population in terms of age, gender and ethnic background, is not intended to be seen as representing the views of all patients and members of the public, but rather a snap shot of a variety of views to inform our work.

5.3 We sought views on the format and content of the publishable reports, as well as other aspects of the proposals in relation to access and availability of information and inspection reports. (See paragraph 2.4 above for detail on the key findings.)

5.4 We also commissioned a YouGov survey of 2,040 members of the public. (See paragraphs 2.11 and 2.12 above for detail on the key findings.)

Pharmacy focus groups and roundtables

5.5 As described above, we held three large roundtable meetings in London, Cardiff and Edinburgh in June 2018 with multiple stakeholders. The roundtable meetings were attended by pharmacy stakeholders including representatives from professional membership bodies for pharmacists and pharmacy technicians; multiples and independent pharmacies; NHS organisations; public health organisations; community and hospital pharmacy; and other stakeholders

5.6 We also held several roundtable meetings with other pharmacy organisations and stakeholders as opportunities arose to do so, as detailed above in paragraph 5.1.k.

6. Date, method and results of consultation

6.1 The consultation on developing our approach to regulating registered pharmacies was open for 12 weeks (17 May 2018 – 9 August 2018). As part of the consultation survey, we included several questions about the broad impact of the proposals in the consultation. The following questions were relevant to the impact on groups with a protected characteristic [listed in Section 3]:

- Question 19: "What kind of impact do you think the proposals will have on people using pharmacy services?"
- Question 22: "Do you think anything in the proposed changes would have an impact – positive or negative - on certain individuals or groups who share any of the protected characteristics listed above" [in Section 3]
- Question 23: "Do you think there will be any other impact of our proposals which you have not already mentioned?"

We analysed the responses provided to these questions below. And they are integrated in section 8 of the EIA. Further analysis can be found in the consultation report[12] itself.

6.2 In total we received 812 written responses. The number of respondents who identified themselves as individuals was 685 and those saying they were responding on behalf of organisations numbered 127. 5 responses were from individuals and organisations writing more generally about their views. There were 807 responses to the online survey. Of these 807:

- All 807 respondents answered questions 19, 20, 21 and 22.
- 161 respondents provided comments to question 23.

6.3 The results for Question 19 were as shown below:

- 273 respondents provided further comment

[12] Developing our approach to regulating registered pharmacies: Consultation report

What kind of impact do you think the proposals will have on people using pharmacy services?	N and % individuals	N and % organisations	Total
Positive impact	184 (27%)	26 (21%)	**210 (26%)**
Negative impact	54 (8%)	13 (11%)	**67 (8%)**
Both positive and negative impact	325 (48%)	61 (50%)	**386 (48%)**
No impact	86 (13%)	16 (13%)	**102 (13%)**
Don't know	35 (5%)	7 (6%)	**42 (5%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

6.4 The comments about the impact on people using pharmacy services fell into four main themes. It was thought that our proposals would drive up quality and lead to improvement in the quality of services for all pharmacy users and increase public trust and confidence in pharmacy and would empower patients by giving them information to make choices. Some commented that the proposals would not make much difference about which pharmacy people would choose to use as they would rely on their own personal experiences and convenience rather than on reports online. A few people said that the publication of reports may mislead or confuse the public and cause those who were not able to access alternative pharmacy services concern.

6.5 The results for Question 22 were as shown below:

- 137 respondents provided further comment

Do you think anything in the proposed changes would have an impact – positive or negative – on certain individuals or groups who share any of the protected characteristics listed above?	N and % individuals	N and % organisations	Total
Yes	113 (17%)	17 (14%)	**130 (16%)**
No	380 (56%)	75 (61%)	**455 (56%)**
Don't know	191 (28%)	31 (25%)	**222 (28%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

6.6 The impact on people with protected characteristics was that there were mostly no adverse impacts predicted. There were comments that there might be adverse effects on the elderly, those with learning difficulties, language and literacy issues as well as IT literacy and access in relation to being able to access inspection reports published online. Employees with mental health issues, and

employees who were pregnant were suggested as groups who could be potentially affected by pressure resulting from unannounced inspections and the publication of poor results. However, there were many comments about how these proposals would have a positive impact for pharmacy service users generally as services will be improved. Other positive impacts that were mentioned were increased transparency and accessibility for pharmacy service users.

6.7 The results for Question 23 were:

- 161 respondents provided comments to question 23 about whether they thought there would be any other impacts of our proposals which have not already been mentioned

6.8 There were no other impacts (on people with protected characteristics) identified in these responses. Approximately half of the respondents leaving comments said that they did not think there were any other impacts, or did not know. The impacts mentioned in these comments echoed those mentioned in the answers to the previous impact questions and are incorporated into those sections.

6.9 The impact questions asked in the consultation were broad. And from the detailed comments received we have incorporated them in the relevant equality areas in section 8 below, or in the regulatory impact annex in section 11 below, as appropriate and relevant.

6.10 We have looked in particular at the views where our proposals are thought to have an impact and how to mitigate this where possible.

6.11 We analysed the responses provided by respondents to the consultation. They are integrated in section 8 of the EIA.

6.12 Please refer to our analysis of consultation responses for further detail on the methodology, and the results.

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

7.1 Please refer to our analysis of consultation responses for details of the outcomes.

7.2 All issues relating to equality and diversity identified through the engagement and consultation process have been set out in detail in Section 8 below.

7.3 Issues relating to the regulatory impact have been detailed in Section 11 below, the Regulatory Impact Annex.

8. Full impact assessment

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

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

8.1 Respondents to the consultation identified internet use as a potential barrier to some older people accessing inspection reports which will be published online. The latest results from the Office for National Statistics (ONS) on Internet Users in the UK[13] say that virtually all adults aged 16 to 34 years were recent internet users (99 per cent) in 2018, compared with 44 per cent of adults aged 75 years and over. According to Age UK[14], internet use among older age groups has increased substantially over the last five years, but many are still non-users.

8.2 From the data from the equality monitoring questions in the consultation, which were optional to answer and not compulsory, the ages of respondents were evenly distributed between the 25-34 years, 35-44 years and 45-54 years ranges with a similar number in the last two age ranges together (the 55-64 years and 65+ years age range). A total of 519 people answered this question, (26 skipped this question). A small percentage did not answer the question and preferred not to say which age group they were in.

What is your age?	Response per cent	Response Total
16-24 years	1 per cent	7
25-34 years	20 per cent	102
35-44 years	23 per cent	119
45-54 years	25 per cent	129
55-64 years	17 per cent	89
65+ years	6 per cent	32
Preferred not to say	8 per cent	41

8.3 From the data from the equality monitoring questions at the patient focus groups, which were optional to answer and not compulsory, the ages of attendees were as shown below. A total of 57 people answered this question, (2 did not answer this question).

What is your age group?	Response per cent	Response Total
16-24 years	8 per cent	5
25-34 years	12 per cent	7
35-44 years	21 per cent	21
45-54 years	8 per cent	8
55-64 years	14 per cent	14
65+ years	3 percent	2
Did not answer	3 per cent	2

[13] Office for National Statistics (ONS): **Statistical Bulletin: Internet users, UK: 2018**

[14] **The Internet and Older People in the UK – Key Statistics**

8.4 From the data from the equality monitoring questions in the YouGov survey, of 2040 people, the weighted base of age ranges were as shown below, (due to the weighting, the response totals have been rounded up and add up to 2041):

Age group	Response per cent	Response Total
18-24 years	11 per cent	229
25-34 years	15 per cent	307
35-44 years	17 per cent	347
45-54 years	16 per cent	333
55+ years	41 per cent	825

8.5 One of our proposals involves the publishing of inspection reports. Several respondents identified that the publishing of reports online would not be accessible to all, for instance older people who may not have access or the IT skills to find and read the reports. And that therefore this group may be disadvantaged compared to younger age groups who would have access to this information in a format that they are familiar with and routinely access. The ONS report for 2018 highlighted that the gap is closing between older and younger groups accessing the internet. They ONS say that since the survey began in 2011, adults aged 75 years and over have consistently been the lowest users of the internet. In 2011, 20 per cent of adults aged 75 years and over were recent internet users, rising to 44 per cent in 2018. And recent internet use in the 65 to 74 age group increased from 52 per cent in 2011 to 80 per cent in 2018, closing the gap on younger age groups.

8.6 Our proposals should be beneficial for all pharmacy users, including older people. Publishing inspection reports will drive improvements in services. The benefits will be seen by older people who cannot access the reports in the same way as other pharmacy users will see the benefits, whether they are able to access the reports or not. All age groups up to the age of 74 access and use the internet often.

8.7 Some respondents commented that the lack of mobility would limit the choice of older people to choose a different pharmacy, if the one they use had received an outcome of ‘‘standards not all met’’. Our monitoring and regulation of pharmacies does not leave pharmacies to remain in a position where they do not meet our standards. Through our various enforcement mechanisms pharmacies must take steps to meet the standards within a certain time. And the progress of improvements is monitored by the inspection team to ensure that they are made. 85 per cent of pharmacies meet all the standards at inspection. Once the enforcement mechanisms are put in to place, 99 per cent of pharmacies meet all the standards within time limits set. From the YouGov survey 45 per cent of people responded that they would be likely to continue to use a pharmacy that had received an outcome of ‘‘standards not all met’’, (39 per cent said that they would not). However, when told about how we use improvement action plans those proportions changed. Taking these plans into account and that we would be monitoring them, 68 per cent of people responded that they would be likely to continue to use a pharmacy that had received an outcome of ‘‘standards not all met’’, (19 per cent said that they would not).

8.8 We will work with support organisations such as Age UK and Carers UK to highlight to harder to reach older people that inspection reports will be available online if they wished to see them, and assist such organisations with their usual channels to improve access to online resources. Local Healthwatch

organisations will also have access resources and be able to assist. We are in the process of looking at how we could make the most of communication as a powerful regulatory tool to help enable the safe and effective practice of pharmacy. This includes communicating directly with the public and forging links with patient and public representative groups to make them more aware about the standards of quality they should expect from pharmacy and educating them on what good looks like and potential risks. This means they will be able to make informed choices. And, in doing so we will be harnessing them to be part of minimising risks to patient safety and driving improvements in quality. To be effective we will be engaging and communicating more to ensure we understand their needs, views and concerns.

8.9 We do not envisage any other significant equalities impact of the proposals in relation to age.

Disability – consider environmental, social and attitudinal barriers

8.10 From the data from the equality monitoring questions in the consultation, which were optional to answer and not compulsory, 4 per cent of people said that they considered themselves disabled. 87 per cent said that they were not disabled and 9 per cent of respondents preferred not to say. A total of 512 people answered this question, (33 skipped this question). From the patient focus groups 24 per cent considered themselves disabled, 69 per cent said that they were not and 7 per cent preferred not say or did not answer this question.

8.11 The Results from the Family Resources Survey for financial year 2016 to 2017, providing information on income and circumstances of UK households15 published by the Department of Work and Pensions in March 2018, say that 22 per cent (13.9 million) of people reported a disability in 2016/17. This uses the core definition of disability in the Equality Act 2010, where a person is considered to have a disability if they report a long-standing illness, disability or impairment which causes substantial difficulty with day-to -day activities.

8.12 We heard that some people with disabilities (in particular, learning difficulties and those with literacy and numeracy difficulties) might find it difficult to access resources online, such as inspection reports. As part of the feedback we have sought to assess the impact of our proposals on people with disabilities.

8.13 We will also consider any requests for copies of any inspection reports in another language and format (such as large print or Braille) and provide these.

8.14 Several respondents considered that our proposals could affect staff with disabilities working in a pharmacy, potentially placing additional pressure on those with a disability due to a mental health issue.

8.15 Whilst we have heard these concerns, a large number of comments said that there would be no negative effects on this group, or could not foresee any potential negative impacts on people with disability. There were also multiple comments which expressed the view that our proposals would be beneficial to all pharmacy users including those with disabilities, by empowering pharmacy users, being open and transparent and encouraging and incentivising pharmacies to improve.

8.16 We do not envisage any other significant equalities impact of the proposals in relation to disability.

[15] **The Results from the Family Resources Survey for financial year 2016 to 2017, providing information on income and circumstances of UK households**

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

8.17 In the consultation it was suggested that our proposals may lead to better services and delivery of services for certain groups, for example gender reassignment individuals. And in particular, that this may lead to pharmacies providing better confidentiality for pharmacy users at the pharmacy counter and when picking up prescriptions.

8.18 Other comments expressed the view that our proposals would be positive and beneficial to all pharmacy users and groups. Groups that fear discrimination are able to exercise more informed choice without having to personally visit the pharmacy.

8.19 We do not envisage, nor have evidence to suggest, any significant equalities impact of the proposals in relation to gender reassignment.

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

8.20 From the responses to the consultation, and the focus groups, we did not hear of any issues relating to marriage or civil partnerships. This means we cannot fully assess whether our proposals are likely to have differing impacts on anyone in these groups.

8.21 However, we do not envisage, nor have evidence to suggest, any significant equalities impact of the proposals in relation to marriage or civil partnership.

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

8.22 In responses to the consultation, a few comments suggested that additional pressure would be placed on pregnant members of the pharmacy team working in the pharmacy or on pregnant pharmacy owners. And that there may be more pressure on pregnant pharmacy owners and pregnant pharmacy employees of publishing inspection reports (especially if the reports show an outcome of "not all standards met") and unannounced inspections.

8.23 We do not envisage, nor have evidence to suggest, any significant equalities impact of the proposals in relation to those who are pregnant or on maternity leave.

Race – consider impact on people of different ethnic groups, nationalities, gypsies, travellers, languages etc.

8.24 In the UK, 87 per cent of people are white, and 13 per cent belong to a black, Asian, Mixed or Other ethnic group. As part of our feedback received we have sought to assess the impact of our proposals on people of different race.[16]

[16] **Ethnicity facts and figures**

8.25 From our consultation response equality monitoring form, which were optional to answer and not compulsory, regarding the race of respondents, the majority of respondents identified themselves as British, (56 percent); and others as Indian, (13 per cent); Other white background, (6 per cent); African, (4 per cent); Pakistani, (3 per cent); and Chinese or Chinese British, (2 per cent). 10 per cent of respondents preferred not to say. A total of 517 people answered this question, (28 skipped this question).

8.26 The patient focus group identified themselves as British, (64 percent); and others as Asian or Asian British, (16 per cent); and Black or Black British, (10 per cent). 3 per cent of respondents did not answer.

8.27 The percentage of different races who responded were more highly represented here than in the general population of the UK. This gave ample opportunity for this group to identify any potential impacts.

8.28 Quite a few respondents felt that language would be a barrier to accessing information online, in particular, in relation to published inspection reports, (see also section on Welsh language scheme below, section 10).

8.29 Many online tools (for example Google translate) now exist which enable the translation of text and documents by people wishing to access resources themselves. Many of these are available free of charge also. Our inspection reports are currently written in plain English and will continue to be written in an accessible way when they are published, which will make it easier for them to be translated.

8.30 We will also consider any requests for copies of any inspection reports in another language and format (such as large print) and provide these.

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

8.31 We heard from a range of respondents, some identifying with a religion and those having no religion, but none raised any particular concerns. From our consultation response equality monitoring form, which were optional to answer and not compulsory, 41 per cent of respondents said that they were Christian; 23 per cent said that they had none; 8 per cent were Hindu; 7 per cent were Muslim; 3 per cent were Sikh. (14 per cent preferred not to say.) A total of 515 people answered this question, (30 skipped this question).

8.32 We do not envisage, nor have evidence to suggest, any significant equalities impact of the proposals in relation to different religions or beliefs or none.

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

8.33 From our consultation response equality monitoring form, which were optional to answer and not compulsory, 49 per cent respondents were female, 44 per cent were male, 1 per cent replied other and 6 per cent of respondents preferred not to say. A total of 522 people answered this question, (23 skipped this question).

8.34 From our patient focus group, 65 per cent of attendees were female, 32 percent and 3 per cent did not answer. The YouGov survey reported that 51 percent of respondents were female and 49 per cent were male.

8.35 The patient focus group highlighted that our proposals would affect carers, as more frequent users of pharmacy services. The majority of those with caring responsibilities are women, according to Carers UK17 and the 2011 Census. They say that almost 6 in 10 (58 per cent) of carers at the last Census (2011) were women. Caring falls particularly on women in their 40s, 50s and 60s, with 1 in 4 women aged 50-54 having caring responsibilities for older or disabled loved ones, compared to 1 in 6 men. Women are also overrepresented in those providing 'round the clock' care, with 60 per cent of those caring for over 50 hours a week being female. This was identified as a group that would be more interested in the quality of the pharmacy services being provided and more likely to look for information and inspection reports on pharmacies before choosing which one to use.

8.36 As mentioned above in paragraph 8.8, we are in the process of looking at how we could make the most of communication as a powerful regulatory tool to help enable the safe and effective practice of pharmacy. This includes communicating directly with the public and forging links with patient and public representative groups, such as Carers UK, to make them more aware about the standards of quality they should expect from pharmacy and educating them on what good looks like and potential risks.

8.37 We think that our proposals will impact this population positively, empowering them and giving them more information and transparency and detail about the pharmacy they may choose to use.

Sexual Orientation – consider impact on bisexual, gay, heterosexual or lesbian

8.38 From the data from the equality monitoring questions in the consultation, which were optional to answer and not compulsory, 81 per cent of people said that they heterosexual / straight; 3 per cent said they were a gay man; less than 1 per cent said that they were a gay woman / lesbian; less than 1 per cent said they were bisexual or other. 15 per cent preferred not to say. . There was no indication that our proposals are likely to have differing impacts on anyone in relation to sexual orientation.

8.39 However, we do not envisage, nor have evidence to suggest, any significant equalities impact of the proposals in relation to sexual orientation.

9. Welsh Language Scheme

9.1 A Welsh version of the consultation document was provided. This ensured that Welsh speaking stakeholders had the opportunity to provide input.

9.2 We will also be publishing inspection reports in Welsh, for pharmacies in Wales.

[17] Carers UK - **Response to Women and Equalities Committee Gender Pay Gap Inquiry 2015**

10. Monitoring

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

10.1 This analysis is intended to assist Council in considering whether the changes proposed to the way we inspect pharmacies should be approved.

10.2 Once the new approach has been approved and implemented, we will continue to gather feedback and data on the performance of the inspection cycle and evaluate the approach to ensure that it continues to provide the necessary level of assurance about the safety and suitability of pharmacies to provide services to the public.

10.3 We will continue to use any feedback in the refining of the inspection model and the way in which we regulate pharmacies. And we will monitor any other equality concerns that emerge and how we will mitigate against them.

10.4 We will also continue to work with the GPhC's Equality, Diversity and Inclusion (EDI) Leadership group to update and review this Impact Assessment, as and when appropriate.

What is the timetable for monitoring, with dates?

10.5 The performance of the inspection cycle will continue to be monitored on a quarterly basis by our Council.

10.6 There will continue to be periodic quality assurance reviews and audits every 6 months on inspection reports.

10.7 The feedback from pharmacies and pharmacy owners will continue to be requested from pharmacies at the end of each inspection and will also be reviewed periodically (quarterly or every 6 months), to ensure that the new approach is working effectively.

Annex A: Regulatory Impact Analysis

11. Regulatory Impact Questions in the Consultation

11.1 The analysis in this annex focuses on the regulatory impact of the proposals detailed in the consultation. This analysis is separate to the analysis of the Equality, Diversity and Inclusion (EDI) issues set out above in the previous sections.

11.2 The consultation on developing our approach to regulating registered pharmacies was open for 12 weeks (17 May 2018 – 9 August 2018). As part of the consultation survey, we included several questions about the impact of the proposals in the consultation: In total we received 812 written responses from 127 organisations and 685 individuals in the survey. 5 responses were from individuals and organisations writing more generally about their views. There were 807 responses to the online survey.

11.3 From these 807 responses to the online survey:

- All 807 respondents answered questions 20 and 21.
- 161 respondents provided comments to question 23.

11.4 The questions concerned with the regulatory impact were:

- Question 20: "What kind of impact do you think the proposals will have on the owners of registered pharmacies?"
- Question 21: "What kind of impact do you think the proposals will have on the pharmacy team?"
- Question 23: "Do you think there will be any other impact of our proposals which you have not already mentioned?"

11.5 The results for Question 20 are shown below:

- 262 respondents provided further comment

What kind of impact do you think the proposals will have on the owners of registered pharmacies?	N and % individuals	N and % organisations	Total
Positive impact	133 (19%)	20 (16%)	**153 (19%)**
Negative impact	119 (17%)	25 (20%)	**144 (18%)**
Both positive and negative impact	355 (52%)	68 (55%)	**423 (52%)**
No impact	32 (5%)	5 (4%)	**37 (5%)**
Don't know	45 (7%)	5 (4%)	**50 (6%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

11.6 The responses to the consultation indicated that the impact on owners was likely to be both positive and negative. Views were expressed that the proposals could increase the pressure that owners felt, and require resources to improve practice, conditions, staffing and patient safety. This could be a drain on resources already under pressure for other reasons, but would ultimately have positive consequences for patients and the public. There were many comments which said that the proposals would encourage improvement and better services to be provided and would lead to good pharmacies getting better and poorer pharmacies improving.

11.7 Part of the reason that views on the potential impact were mixed was that it was thought that it would be dependent on how the pharmacy was performing. Good and positive reports could bolster team morale and the pharmacy's performance, the owner's pride in their pharmacy as well as local recognition and wider enhancement of the pharmacy profession amongst the public. However, if the pharmacy was not performing well and not meeting standards then potentially it was thought that this could be negative and have an economic impact on failing pharmacies if the public used this information to choose which pharmacies to use, or service commissioners used this information. Rather than prompt pharmacies to improve, negative results may demoralise the team, prompt more complaints. Although there were comments that the negative impacts would be short lived and would ultimately lead to the necessary improvements and improved standards.

11.8 Unannounced inspections were described as being potentially negative as it would not allow the owner to prepare for an inspection and there could be patient safety concerns if the pharmacy was very busy and thought that the inspection could be disruptive. Inspectors generally do not currently specify a date and time for their inspection visit, and are also able to inspect without any prior notification being sent. The inspection team are all registered pharmacy professionals and understand the importance of minimising any impact (disruption and interruptions) on the pharmacy team during the inspection, especially when they are interacting with pharmacy service users. There are positive benefits for the public if the pharmacy owner needs to make sure that their pharmacy is meeting all the standards every day, continually, rather than just for a temporary period of 6 weeks when they have been notified that the inspector could visit. This was mentioned in several comments as being potentially relevant, and beneficial, in relation to staffing levels.

11.9 Sharing good practice and the knowledge hub were mentioned many times as being a positive proposal for owners as it will enable them to see examples of practice to emulate.

11.10 The results for Question 21 are shown below:

- 291 respondents provided further comment

What kind of impact do you think the proposals will have on the pharmacy team?	N and % individuals	N and % organisations	Total
Positive impact	138 (20%)	18 (15%)	**156 (19%)**
Negative impact	149 (22%)	27 (22%)	**176 (22%)**
Both positive and negative impact	367 (54%)	68 (55%)	**435 (54%)**
No impact	10 (1%)	5 (4%)	**15 (2%)**
Don't know	20 (3%)	5 (4%)	**25 (3%)**
Total N of responses	**684 (100%)**	**123 (100%)**	**807 (100%)**

11.11 As described above, in paragraphs 11.6 – 11.8, the views were that there would be a mixed impact largely dependent on how the pharmacy was performing and the outcome of the inspection. If the pharmacy received a positive outcome then there would be a morale boost for the pharmacy team, a more positive environment and positive impact with further improvements in services for pharmacy users. And there would be willingness to share and publicise the good outcome.

11.12 If the result was a negative outcome, then there would be reluctance to want that outcome to be widely known. The negative outcome could potentially have a negative effect on the pharmacy team (irrespective of how widely this outcome was shared with others outside the pharmacy team). This could demoralise and demotivate staff, and lead to a downward spiral. At the same time, this may be short lived if the pharmacy could make the necessary improvements. This may require an increased workload for, and on, the pharmacy in the short term, but would be beneficial for the pharmacy team (and pharmacy users) in the longer term.

11.13 Positive impacts on the pharmacy team were thought to be that the pharmacy team would be clearer on what they needed to achieve and focus them more on the standards and meeting them. This would lead to better working conditions and be helpful for highlighting where services would need to be improved, and support was needed to meet the standards. The pharmacy team could also learn from other reports and examples of good practice. This could motivate the pharmacy team as they will not want a negative outcome of an inspection. They will want to be meeting all the standards.

11.14 Comments about the negative impacts were that this would add to the administrative burden on pharmacies and their teams. Negative reports could be demoralising and could have an impact on the business. The pharmacy team may be stressed and anxious about unannounced inspections, however as described above in paragraph 11.8 this is not significantly different to the current position as far as the pharmacy team would be concerned. The pharmacy team could be put under pressure to meet the standards which may increase their workload.

11.15 The results for Question 23 were that:

- 161 respondents provided comments to question 23 about whether they thought there would be any other impacts of our proposals which have not already been mentioned

11.16 There were no other (regulatory) impacts identified in these responses. Approximately half of the respondents leaving comments said that they did not think there were any other impacts, or did not know. The impacts mentioned in these comments echoed those mentioned in the answers to the previous impact questions, and have been incorporated into those sections

12. Other relevant regulatory impact assessments and reports

Department of Health – Rebalancing medicines legislation and pharmacy regulation programme

12.1 In February 2015 the Department of Health issued a UK consultation[18] on behalf of the four UK Health Departments to seek views on pharmacy related draft Orders being made under the powers in section 60 of the Health Act 1999.

12.2 One of the draft Orders being consulted on was, at the time, called The Pharmacy (Premises Standards, Information Obligations, etc.) Order 2015. This included a provision to enable the

[18] **Rebalancing Medicines Legislation and Pharmacy Regulation: draft Orders under section 60 of the Health Act 1999 – Consultation document**

publication of inspection reports. It included the following section and question in the consultation document, (on pages 38 and 39):

Publication of GPhC reports and outcomes from pharmacy premises inspections

124. It is proposed to amend Article 9 of the Pharmacy Order 2010 to provide for publication of GPhC reports and outcomes from pharmacy premises inspections. Those changes will make clear that if such a report includes personal data it is assumed under data protection requirements that such information can be published as a result of the GPhC's pharmacy regulation function (paragraph 20 of the draft Order).

> ***Question 13: Do you agree with the changes to provide for publication of GPhC reports and outcomes from pharmacy inspections?***

12.3 A regulatory impact assessment was carried out by the Department of Health at that time, entitled: Department of Health – Rebalancing medicines legislation and pharmacy regulation programme: Registered pharmacy standards and related matters (IA 2 of 2)[19]. This impact assessment contained the following information regarding the provisions which would amend the Pharmacy Order 2010 and enable the publication of inspection reports and the outcome of the inspection (on page 27):

Pharmacy Order 2010 – Pharmacy owners

Article	Requirement	Replacement	Regulatory impact	Cost impact on pharmacy businesses	Comments
Article 9	Clarifies that the GPhC can publish registered pharmacy inspection reports, which may include an account of the outcome of the inspection.	N/A	Clarification of existing expectation so that results of inspections are transparent and publicly available and can be published and shared more widely e.g. with other regulators, NHS commissioners etc. No impact on the volume or frequency of inspections is expected.	Cost neutral	In England, publication of inspection reports by the Care Quality Commission (CQC) is a key driver both to improve public confidence and public choice, and to reward good performance and highlight poor performance, without imposing costs. Retail pharmacies generally do not have to register with the CQC. The new arrangements will enable GPhC to meet consumer

[19] **Department of Health – Rebalancing medicines legislation and pharmacy regulation programme: Registered pharmacy standards and related matters (IA 2 of 2)**

					expectations in ways that are more familiar to them.

12.4 The Department of Health's information indicated that making this change would be cost neutral to pharmacy businesses, would not have any impact on the volume or frequency of inspections carried out.

12.5 This Impact Assessment also described several positive impacts from publishing inspection reports and the outcome of inspections: Transparency of results, sharing information and learning more widely, improving public confidence and choice, rewarding good performance and highlighting poor performance.

12.6 Following the public consultation, in February 2016 the Department of Health published its Report on response to the public consultation on the Pharmacy (Premises Standards, Information Obligations etc.) Order 2016[20]. It included the following section about question 13 in the consultation document, (on pages 13 and 14):

Publication of GPhC reports and outcomes from pharmacy premises inspections

Consultation Question 13:

Do you agree with the changes to provide for publication of GPhC reports and outcomes from pharmacy inspections?

Responses	***Agree***	***Disagree***	***Not Answered***
Number	***113***	***11***	***35***
%	***71%***	***7%***	***22%***

What we proposed

44. It is proposed to amend Article 9 of the Pharmacy Order 2010 to provide for publication of GPhC reports and outcomes from pharmacy premises inspections. Those changes will make clear that if such a report includes personal data it is assumed under data protection requirements that such information can be published as a result of the GPhC's pharmacy regulatory function.

What we heard

45. Out of 159 respondents, 124 answered this question. Of these 91% supported the proposal for the publication of GPhC reports and outcomes of pharmacy inspections.

46. Those who responded positively remarked upon the approach being in line with that adopted by other system regulators, such as the Care Quality Commission and that it supported transparency. However, it was vital that the inspection, rating and reporting system is fair and fit-for-purpose.

[20] **Report on response to the public consultation on the Pharmacy (Premises Standards, Information Obligations etc.) Order 2016**

47. It was suggested that the reports should be accompanied by an appropriate explanation to aid understanding, by members of the public, of the regulations and standards.

48. The concerns expressed by those who did not agree with the proposal and some who did, included that further engagement with stakeholders is needed; inspection grading needs to be addressed; that an appeals process should be available before the publication of the report; and that piloting of the new arrangements should be considered.

Quotes:

''The more information re Pharmacy inspections and reports is made public the better. The information

should be made available via the NHS Choices website''

''This change would be in line with the approach operated by other system regulators such as the CQC''

''Promotes openness and transparency and accountability''.

''We also agree that where relevant personal data needs to be included in reports that this will be in accordance with data protection requirements. Consistency in reporting the outcomes of pharmacy inspections will be even more important when reports are published. GPhC may consider a pilot approach to assess the impact of this change''.

12.7 Support for publication of inspection reports was clear in this group of respondents.

12.8 The concerns raised by those that did not agree have been, and are being, addressed. There has been engagement with stakeholders on the format of reports, the proposals and the grading system. An appeals process before publication is in place and is being piloted. And pilots will be introduced for various proposals before being fully implemented.

12.9 There is further information in this report about whether respondents agreed with the impact assessments that the Department Health carried out. 94 per cent of those that answered that question agreed with the costs and benefits assessments for the pharmacy premises standards proposals.

The King's Fund research on the Impact of the Care Quality Commission on provider performance: room for improvement?

12.10 This report[21] on the CQC's impact describes eight ways in which regulation can affect provider performance. It shows that regulation has an impact before, during and after inspection and through interactions between regulators, providers and other key stakeholders.

12.11 One of the eight areas described is Informational Impact whereby the regulator collates intelligence and puts information about provider performance into the public domain or shares it with other actors who then use it for decision making (e.g. commissioning, patient choice).

[21] **Alliance Manchester Business School and The King's Fund research on the Impact of the Care Quality Commission on provider performance: room for improvement?**

12.12 Published information seems to provoke action primarily amongst the providers of services themselves and particularly in response to a poor outcome. The public has a right to know how services are performing, yet the research seemed to indicate that they did not use this information to choose services (the exception being social care users and their families choosing a care home, who did refer to reports to help them make a decision about service providers to avoid). If the public took a similar approach to choosing which pharmacy to use this will drive improvement and encourage pharmacies to meet the standards.

13. Monitoring

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

13.1 This analysis is intended to assist Council in considering whether the changes proposed to the way we inspect pharmacies should be approved.

13.2 Once the new approach has been approved and implemented, we will continue to gather feedback and data on the performance of the inspection cycle and evaluate the approach to ensure that it continues to provide the necessary level of assurance about the safety and suitability of pharmacies to provide services to the public.

We will continue to use any feedback in the refining of the inspection model and the way in which we regulate pharmacies. And we will monitor any other regulatory impact concerns that emerge and how we will mitigate against them.

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

13.3 The results from the consultation, the patient focus groups, and the YouGov survey have informed the approach we intend to take to regulating pharmacies, how we will inspect, what we will publish and how we will publish inspection reports, improvement action plans and learning and examples of notable practice.

13.4 The issues identified through this analysis will be taken into account when deciding on the approach and the implementation of our proposals.

What is the timetable for monitoring, with dates?

13.5 The performance of the inspection cycle will continue to be monitored on a quarterly basis by our Council.

13.6 There will continue to be periodic quality assurance reviews and audits every 6 months on inspection reports.

13.7 The feedback from pharmacies and pharmacy owners will continue to be requested from pharmacies at the end of each inspection and will also be reviewed periodically (quarterly or every 6 months), to ensure that the new approach is working effectively.

13.8 We will continue to update and amend this Impact Assessment as and when appropriate.

Meeting paper

Council on Thursday, 08 November 2018

Public business

Strategic plan 2017-20

Purpose

To update the GPhC strategic plan for 2017-20.

Recommendations

The Council is asked to:

i. agree that the current Strategic plan 2017-20 should be updated with some revisions to the Foreword;

ii. provide feedback on the draft revised Foreword, to be finalised by the Chair and Chief Executive in the light of that feedback.

1. Introduction

1.1. We have a statutory obligation to submit a strategic plan annually to the Privy Council Office, to be laid before Parliament and the Scottish Parliament.

1.2. The current strategic plan for 2017-20 was agreed by Council in October 2017 and can be found **here**.

1.3. As in previous years, the strategic plan will be complemented by a more detailed business plan, which will be considered by Council before the start of the next financial year.

2. Key considerations

2.1 In agreeing the current strategic plan 2017-20 the Council had a clear intention to set the strategy for a three-year period. If there were not a statutory requirement to lay a strategic plan annually it is doubtful that the three-year strategy, agreed two years ago, would require any significant change. The exception to this being some major new external change requiring a fundamental strategic re-think.

2.2 Although the considerations outlined in paragraph 2.1 remain valid, the statutory requirement to submit a strategic plan annually provides a useful prompt to carry out an interim review of the strategic plan.

2.3 Informal discussions with Council members and work done by the executive has highlighted that the content and body of the strategic plan remains valid for the last year of this Strategic plan. The topical issues in our external environment highlighted in the Foreword to the Strategic plan also remain relevant and valid, albeit that the pace of change in these has accelerated. In particular, continued pressures and challenges on the wider health and social care system combined with the opportunities from advancements in new technologies, medicines and treatment pathways is driving changes in the way services and care are received and accessed by patients and the public. This also includes how those services are structured. All of these will continue to have an impact on the 'how' and the 'what' we regulate going forward.

2.4 In light of the pace of change highlighted in 2.3 above, we have identified the need to develop a longer-term planning horizon to ensure we are fit to deliver efficient and responsive regulation which is relevant to the changing healthcare environment. We are therefore currently developing a 10-year vision and strategy, focussing more of our efforts in proactively anticipating and responding to issues and tailoring our regulatory responses.

2.5 This means that the coming third year of this strategic plan will be a transitional period as we continue to complete and set our longer-term goals and develop our plan to achieve these.

2.6 With these considerations in mind, a revised draft Foreword has been prepared signalling our work to develop a longer term 10-year vision, and is attached for comment. The proposal is that the body of the strategic plan itself should not be changed, such that the strategic plan to be submitted for laying before the Parliaments will be in the same terms as the one submitted a year ago, with an updated Foreword.

3. Equality and diversity implications

3.1. Equality, diversity and inclusion issues will continue to be considered and identified explicitly in all workstreams which follow as part of our business planning.

3.2. The strategic plan itself specifically highlights the diversity in healthcare and pharmacy within and between the countries of Great Britain, which reflects our devolution strategy.

4. Communications

4.1. The strategic plan itself, once [re-]laid before Parliament and the Scottish Parliament, serves a formal communication purpose as one of our core corporate publications.

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

5. Resource implications

5.1. The strategic plan reflects a continuity of approach and as such does not include any specific new initiatives. As usual, the detailed evaluation of resource implications is taking place as part of our annual corporate planning and budgeting process.

6. Risk implications

6.1. Our risk management work and processes relate back to our strategy inasmuch as we define risk in terms of threats to the achievement of our objectives. We have work to do, under the guidance of the Audit & Risk Committee, to further integrate our strategic and business planning with our risk identification, measurement and mitigation work.

Recommendations

The Council is asked to:

i. agree that the current Strategic plan 2017-20 should be updated with some minor revisions to the Foreword;

ii. provide feedback on the revised Foreword, to be finalised by the Chair and Chief Executive in the light of that feedback.

Duncan Rudkin
Chief Executive
General Pharmaceutical Council

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8 November 2018

Appendix 1

December 2018

Since 2017 we have been working to deliver the aims set out in our three-year strategic plan. This plan describes our ambition to support and improve the delivery of safe, effective care in pharmacy, and also describes our strategic approach and operating principles for achieving that ambition.

During the last twelve months – the second year of the strategic plan – we have made significant progress under our three key goals, which are to make sure:

- the pharmacy team have the necessary knowledge, attitudes and behaviours
- registered pharmacies deliver safe, effective care and services, and
- pharmacy regulation is efficient and effective

Here are some of our achievements under our key goals:

- We successfully introduced revalidation for pharmacy professionals, including the creation of a new online portal enabling them to manage their records efficiently and effectively alongside their annual registration renewal applications.
- We implemented new standards for the initial education and training of pharmacy technicians, and new criteria for registration as a pharmacy technician.
- We consulted on developing our approach to regulating registered pharmacies, including publishing inspection reports for the first time, and are using what we heard to help develop and refine our approach.

We are continuing to make good progress in achieving the aims set out in our strategic plan. But as we prepare to enter the final year of this strategic plan, and look ahead to the future, we are conscious of significant challenges facing society in general which will impact on pharmacy and on pharmacy regulation too. Just a few of these challenges are highlighted below.

Economic uncertainty and the continuing squeeze on public finances – seen in the wider NHS – are also affecting pharmacy services. The decision to exit from the European Union continues to cause uncertainty and the extent of its impact on pharmacy and pharmacy regulation is not yet clear. We need to be ready to respond effectively to any future developments.

There may also be fundamental changes coming to the way our economy operates, because of the effects of new technologies such as artificial intelligence and machine learning. These may bring benefits

which were not previously considered possible. However, change of this kind will also bring risks and challenges. We will also need to consider how these changes will affect people using pharmacy services, and what – if any – risks there may be and our role in mitigating them.

We have known for some time that financial pressures, population changes and public health challenges mean our health services will have to adapt. Governments across Great Britain believe pharmacy is part of the solution and will need to operate differently in the future. In the next 20 years we expect the percentage of the UK's population aged over 65 to rise from 18% to 24%. This will put more pressure on our health and care system, to an extent we have never seen before. We also face ongoing public-health challenges, which pharmacy is well placed to play a major part in dealing with.

Decisions about how the sector should change are primarily for governments, commissioners and the sector itself to make. But it is clear that the way pharmacy services are delivered will change significantly, with pharmacy professionals more likely to work in multidisciplinary teams, and pharmacy services looking to make use of new technology, for example. As a regulator, we know we will also have an important role to play – working with governments, patients and others.

The pace of change in pharmacy is increasing, and it has prompted us to begin to work on a longer-term plan. We are currently developing on a 10-year vision and strategy, which will enable us to make sure that we are fit to deliver efficient, responsive regulation which is relevant to the changing healthcare environment. We will focus more of our efforts on proactively anticipating and responding to issues, and tailoring our regulatory responses to achieve the desired results in the best and quickest way.

This means that the coming third year of this strategic plan will be a transitional period as we continue to set our longer-term goals and develop our plan to achieve these. We will need to keep our strategy under close review to make sure we are adapting quickly to the challenges described and are not standing in the way of innovation that is focused on delivering improved outcomes for patients.

We also know that we are uniquely placed to use our privileged position to capture and share data, research and information. We can use this to:

- provide assurance to patients and the public
- help us better understand risk in pharmacy, and
- enable and encourage improvement in the sector

We aim to use data more effectively to evaluate the impact of our regulatory work.

These ambitions are very much in line with the direction of public policy on professional regulation. Our strategy is designed to be able to adapt and respond to the challenges we face and to make good use of the opportunities that arise, and we will be developing our longer-term plan to do the same.

Meeting paper

Council on Thursday, 08 November 2018

Public business

Revising standards for the initial education and training of pharmacists

Purpose

To present Council with a consultation document for revised initial education and training standards for pharmacists.

Recommendations

The Council is asked to agree the standards consultation document.

Introduction

1.1 One of the core functions of the GPhC is setting standards for the initial education and training of its registrants, in this case, pharmacists. The current standards date from 2011 and were implemented in 2012. Due to the five years of study and practical experience required, the first cohort of students began work in 2017. Given the rapidly evolving nature of pharmacy practice we believe the standards need to be revised to ensure the pharmacists of the future have the necessary knowledge, attitudes and behaviours.

1.2 We began the revision process in 2017 with pre-consultation meetings with all schools of pharmacy, Health Education England, NHS Education Scotland, (the now) Health Education and Improvement Wales, the Royal Pharmaceutical Society, the British Pharmaceutical Students Association and other stakeholders. After that we convened three expert drafting groups covering learning outcomes, pre-registration training and prescribing. We also established an education advisory group, with membership from across the profession, the three countries of Great Britain and members from the Pharmaceutical Society of Northern Ireland along with patient representatives. The consultation document takes account of the feedback obtained.

Key changes

2.1 The key changes we are proposing in the following areas:

- *Learning outcomes*: focused on four themes – person-centred care; professionalism; professional knowledge and skills; and collaboration. The learning outcomes retain the critical importance of science as the underpinning feature of initial education and training for pharmacists but have a greater focus on applying that scientific knowledge in practice. The learning outcomes are more heavily focused on clinical skills and the importance of communicating effectively with patients and members of the public and multi-professional learning.

- *Integrating the five years of initial education and training*: In order to deliver the learning outcomes with the increased focus on clinical skills, we believe it is essential to integrate more closely the five years of study and practical experience. As a result, we are setting the learning outcomes to be achieved over five years. That will require universities, employers, health education and training organisations and those responsible for funding to work collaboratively to achieve this. It is not our role to specify precisely how this can be achieved. We believe there are likely to be different ways and models both within and across the countries of Great Britain. We will ensure that our accreditation methodology allows for diversity and innovation in delivery.

- *Learning in practice*: as we are setting learning outcomes for five years, it follows there will be no separate set of pre-registration performance standards. The learning in practice components of the course will count towards the registration requirement for 52 weeks of practical learning. We will expect a more rigorous and structured approach to learning in practice with more regular and documented progress meetings.

- *Selection and admission:* we propose to strengthen the standard by requiring course providers to assess the values of prospective students in addition to their academic qualifications. To help achieve this we will require course providers to conduct face-to-face interviews with prospective students.

- *Equality and diversity*: we propose to strengthen the standard by requiring course providers to conduct an annual review of student performance and admissions by the protected characteristics as set out by the Equality Act 2010. We will also require evidence of the action taken to examine the reasons for any differences and to address the situations where students are disadvantaged.

Equality and diversity implications

3.1 We will be considering equality and diversity implications throughout the development of this policy. The equality impact assessment will be circulated with the finalised standards.

Communications

4.1 Once published, the consultation will run for 12 weeks.

4.2 The consultation will be public and anyone can respond but we will be contacting key stakeholders directly to encourage them to respond.

Resource implications

5.1 The consultation exercise is budgeted for.

Risk implications

6.1 The proposal for closer integration of academic study and practical learning will be challenging and will involve some difficult decisions. It will require a significant change to delivery which will need universities, employers, health education and training organisations and funding bodies to think innovatively and creatively about the ways it can be achieved.

Monitoring and review

7.1 Once agreed, we will monitor and review the implementation and further changes in pharmacy practice.

Recommendations

The Council is asked to agree the standards consultation document.

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October 31st 2018

Consultation on initial education and training standards for pharmacists

December 2018

Contents

About the GPhC

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

Our main work includes:

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

Foreword

There are growing expectations on everyone working within health and care to deliver better experiences and outcomes for patients and the public. It is vital that the pharmacy team are equipped to work flexibly alongside other health and care professionals, and can respond with confidence to the changing demands from health services and patients across Great Britain. Our Strategic plan (2017–20) sets out our aim to use our regulatory powers to support and improve the delivery of safe, effective care and to uphold trust in pharmacy. One of the ways we do this is by continuing to make sure the pharmacy team have the necessary knowledge they need, and display the necessary attitudes and behaviours.

Pharmacists play a vital role in delivering care and helping people to maintain and improve their health and wellbeing. The standards of initial education and training we set for pharmacists are critical in ensuring that pharmacists are appropriately prepared to deliver pharmacy services and improve them. The initial education and training of pharmacists must give them the necessary knowledge, attitudes and behaviours to successfully take on their roles and provide safe and effective care for the people using their services.

Like other healthcare professionals, the pharmacist role is a flexible one and varies between settings and sectors. Whatever the circumstances, pharmacists are experts in medicines. The role's flexibility means that pharmacists can work in registered pharmacies; in primary, secondary and tertiary care; in non-healthcare settings; or in combinations of these.

Pharmacists' roles are evolving quickly in response to rapid changes in healthcare and pharmacy practice. Initial education and training also needs to evolve to reflect these changes so that pharmacists are equipped with the required skills to develop new services.

In this consultation, we are proposing to modernise the initial education and training of pharmacists. This is to take account of recent developments in the delivery of initial education and training, and to give pharmacists the knowledge, attitudes and behaviours they will need to be prepared for future practice.

One important change we are proposing is to set integrated standards for the five years of initial education. At the moment, the most common form of initial education and training for pharmacists in Great Britain is a four-year MPharm degree accredited by the GPhC followed by 52 weeks of pre-registration training in one or more sectors of practice. We currently set standards and learning outcomes for the MPharm degree and then separate performance standards and learning outcomes for the pre-registration year.

We think that now is the time to bring pharmacist initial education and training in to line with other clinical healthcare professions in regard to integrating elements of academic study and workplace experience. We propose to have one set of standards and learning outcomes that cover the full period of education and training before initial registration. We call on stakeholders to work together constructively to bring this about.

We conducted a phase of extensive pre-consultation stakeholder engagement with a wide range of

health and education experts before drafting the revised standards. During that work we heard that working in partnership with patients, working in multi-disciplinary training, leadership skills and using technologies to improve patient care should be strengthened in the revised standards to prepare student pharmacists for their future roles. Also, we heard that this must be underpinned by relevant science.

In this consultation, we hope to hear from as many people and organisations as possible about our proposals and we will use what we hear to shape our standards over the coming months.

Developing the standards

We have considered a range of information in developing these draft standards. We commissioned research to provide us with further intelligence on pharmacists' preparedness for practice. We engaged with all the schools of pharmacy and with many stakeholders involved in the education and training of pharmacists. We also convened several expert groups to test specific aspects of the initial education and training of pharmacists, namely prescribing, pre-registration training and learning outcomes.

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

This consultation document is in three parts:

- Section 1: Introduction to the standards
- Section 2: Standards for the initial education and training of pharmacists
- Section 3: Responding to the consultation

The consultation will run for 12 weeks and will close on **Friday 27 February 2018**. During this time we welcome feedback from individuals and organisations. We will send this document to a range of stakeholder organisations, including pharmacy professionals, professional representative bodies, student pharmacists, organisations representing pharmacy students, education and training providers, employers, and patients' representative bodies.

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

Our report on this consultation

Once the consultation period ends, we will analyse the responses we receive. Our governing council will receive the analysis at a meeting in Summer 2019. It will take the responses into account when considering the final initial education and training standards for pharmacists.

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

How to respond

You can respond to this consultation by going to www.pharmacyregulation.org/IETPstandards and filling in an online survey there.

Please contact us at consultations@ pharmacyregulation.org if you would like a copy of the survey in another format (for example, in hard copy, larger type or in a different language).

Comments on the consultation process itself

If you have concerns or comments about the consultation process itself, please send them to:
feedback@pharmacyregulation.org

or post them to us at:
Governance Team
General Pharmaceutical Council
25 Canada Square
London E14 5LQ

Please do not send consultation responses to this address

Section 1: Introduction

1.1 Background

Education and training gives pharmacists the foundation on which practice is built and the initial education and training standards for pharmacists are an important element of our regulatory responsibilities. The current standards came into effect in 2011 and we have seen considerable developments since then. University degrees are more clinical, there are greater use of placements and examples of inter-professional learning. There is also positive feedback in respect of the first cohort of students who have been educated and trained under these standards.

So why propose new standards at this stage? The pace of change in pharmacy has increased in recent years with greater use of technology, additional services offered and greater expectation that pharmacists can help alleviate some of the pressures in the NHS more widely. The pharmacist's role as a front-line care giver has continued to develop, taking them with ever greater frequency into GP practices and care homes as well as the more familiar settings in community pharmacy, hospitals, industry and academia. Pharmacists need to be equipped to play an important role in providing clinical services to people in these diverse working environments. They will also need to operate in multi-professional teams across healthcare settings working towards improving the health and well-being of people.

We believe that the standards need to be revised to respond to these changes and to anticipate future developments. We have spoken to a wide range of people over the last 12 months to inform our thinking. These include schools of pharmacy, students, employers and an Education Advisory Group including patient representatives.

1.2 The changes to the standards that we are proposing

1.2.1 Learning outcomes

The learning outcomes are focused on four themes: **person-centred care; professionalism; professional knowledge and skills; and collaboration.** The learning outcomes retain the critical importance of science as the underpinning feature of initial education and training of pharmacists. It is the extensive knowledge of medicines that enables pharmacists to play a specific and leading role in healthcare in direct patient-facing roles, research and industry. Given the developments in pharmacy set out in the previous section, we believe the standards need to have a greater focus on applying that scientific knowledge in practice. The standards are therefore more heavily focused on clinical skills and on the importance of communicating effectively with patients and members of the public. This includes the involvement of people in decisions about their care as well as advising people clearly and confidently about their use of medicines. It also includes making sure that students learn skills relating to prescribing such as consultation and physical examination skills. This will provide a basis for their future development as pharmacists if they decide to apply to become a pharmacist independent prescriber after registration. Pharmacists are also increasingly forming part of multi-professional healthcare teams. As services and service models develop, this is likely to increase further. We believe it is essential that pharmacy students have greater involvement with, and exposure to, other health and care professionals from the early stages of their education and training.

We see this increased focus on clinical and communication skills and multi-professional learning as essential to equip pharmacists with the flexibility they will require. We also believe it will develop the confidence of pharmacists to play a leading role in patient care and this is a factor that has been raised with us consistently in development of the standards.

1.2.2 Integrating the five years of initial education and training

The most common form of initial education and training for pharmacists in Great Britain is a four-year MPharm degree accredited by the GPhC followed by 52 weeks of pre-registration training in one or more sectors of practice.

There has been considerable discussion over many years about the potential value of integrating the academic study and practical workplace learning[1]. In recent years we have seen some developments. In England there are now four five-year degrees designed for international students, who can undertake pre-registration training as part of their degree on a student visa. Feedback from the schools of pharmacy running these degrees is positive, with students becoming more confident communicators and able to interact with patients effectively.

In Scotland government policy is to introduce a 5-year integrated initial education and training programme for pharmacists, with aim of providing coterminous graduation and registration. Work is under way to consider the admissions, funding, programme development and quality management arrangements necessary to support this. In addition to this work, the number of funded pre-registration places in Scotland has increased from 170 to 200, in part to expand training opportunities in remote and rural areas, and additional funding has been made available to support the development of additional clinical experiential learning in the current MPharm courses provided by Scottish universities.

In Wales, health boards have been piloting multi-sector training with a view to rolling this out across the country in due course. Rather than training in one sector, trainees experience combinations of placements in community, hospital, GP practices, mental health trusts and care homes as part of a commitment to increase the capability of people to work flexibly in the interests of patients. Similar trials have begun in England and Scotland.

Alongside developments in IET, the Royal Pharmaceutical Society (RPS) are hosting a board to build on their existing Foundation Programme, recognising the potential value of a structured career path for all pharmacists once they join the register.

We believe this increasing focus on closer integration of study and experiential learning (practical experience) and closer collaboration is now essential. To achieve the learning outcomes, we believe there needs to be a more coherent approach to the five years of initial education and training. The greater focus on clinical skills, on communicating with patients and working effectively with other health care professionals requires a much stronger link between the currently separate elements of academic study in the MPharm degree and workplace experience contained in a pre-registration year spent in a hospital or community pharmacy. Student pharmacists need exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competence required.

[1] Medical Education England. (2011) Modernising Pharmacy Careers (MPC) Programme: Review of pharmacist undergraduate education and pre-registration training and proposals for reform

As a result, we are setting the learning outcomes to be achieved over five years. By necessity, that will require universities, employers, health education and training organisations and those responsible for funding to work collaboratively to achieve this.

It is not the role of the regulator to specify precisely how this can be achieved. We believe there are likely to be different ways and models both within and across the countries of Great Britain and we will ensure that our accreditation methodology allows for diversity and innovation in delivery. We do not believe people should feel constrained by earlier discussions about the way greater integration will be achieved and funded.

We recognise that this is challenging and will involve some difficult decisions. But we also believe it is the right time to prompt more innovative thinking given the importance of ensuring that the pharmacists of the future are fully equipped for the roles they will need to play. There would need to be a managed transition from the old standards to the new ones and we will take account of this in deciding when the new standards, once finalised, will come into effect.

1.2.3 Learning in practice (pre-registration training)

As we are setting learning outcomes for five years it follows that there will be no separate set of pre-registration performance standards. The learning in practice components of the course will count towards our registration requirement for 52 weeks of practical training. It will be for course providers and employers to determine when the 52 weeks are carried out and we would expect there to be different models depending on the overall design of each provider's education and training course. We will expect a more rigorous and structured approach to learning in practice with more regular and documented progress meetings.

1.2.4 Selection and admission

We propose to strengthen the standard by requiring course providers to assess the **values** of prospective students in addition to their academic qualifications. Given the learning outcomes we believe are necessary, and the lessons learned more generally from reports and inquiries into healthcare failings, we think this is an important development. With the increased focus on patient-centred care in our proposed learning outcomes, this additional requirement will ensure course providers are thinking more widely about the all-round abilities of prospective students and their suitability to become pharmacists.

To help achieve this, we will also require course providers to conduct face-to-face interviews with prospective students. In addition to informing an assessment of values, it also enables course providers to assess the overall communication skills of prospective students in line with the greater focus on this element within the learning outcomes. This requirement would apply to all admissions, including those students seeking admission to a university through clearing.

We have also considered carefully whether the selection and admissions standard should be strengthened in other ways. We remain concerned that around 20% of people have not passed the registration assessment at their first sitting in the last two years. While there can be many reasons for this, we have noted the wider trend of students entering university having not achieved the advertised

grades – 32% in 2015/16 rising to 39% in 2016/17. That raises the question of whether our standards should require course providers to admit only those students who have demonstrated their academic ability by achieving the A level/Highers grades advertised for a course. While there are some arguments in favour of this, we are very conscious of the aim to widen opportunity of access to university and healthcare professions. We are also aware that students who may not have achieved the advertised grades may nevertheless with the right support, application and values, succeed over the course of their education and training.

We think this issue is best addressed through our accreditation approach and we will be expecting course provides to have clear criteria for deciding when it is appropriate to admit students who have not achieved the advertised grades. We will also expect evidence of the monitoring and support provided to those students.

Schools of pharmacy will be required to have effective measures in place to ensure that, whatever students' academic performance upon entry to the course, only those who have demonstrated over five years that they are capable of achieving the standard required for registration actually progress to graduation. Designated learning in practice supervisors will also not be able to sign off student pharmacists if they have not met the learning outcomes of learning in practice.

We are aware there are strong views on both sides of this argument and we welcome further discussions as part of this consultation.

1.2.5 Equality, diversity and fairness

Initial pharmacy education and training must be based on principles of equality, diversity and fairness. This is contained in the current standards but we are proposing to strengthen it by requiring course providers to conduct an annual review of student performance and admissions by the protected characteristics as defined by the Equality Act 2010. We will also require evidence of the action taken to examine the reasons for any differences and to address situations where students are disadvantaged.

1.3 Future work

1.3.1 The Registration Assessment

The positioning and purpose of the Registration Assessment is something we have discussed with stakeholders at length. In 2016 we made significant changes to it, giving it a clearer focus on the application of clinical knowledge and real-life calculations. We are aware of arguments for further change, including the suggestion that the calculations element of the assessment should be completed at an earlier stage of students' education and training. We are also aware of arguments that organised structured clinical examinations (OSCE) should be used to strengthen assessment of clinical competence. We will consider these issues as part of a detailed look at the Registration Assessment once we have finalised our education and training standards.

1.3.2 The Evidence Framework

After we published our initial education and training standards for pharmacy technicians, we produced an accompanying evidence framework. It gave more information on the standards for course providers and was developed in consultation with them. We will do the same for this set of standards.
The evidence framework will include more information on:

- some of the learning outcomes, especially those that are more open to interpretation than others, and our
- requirements for course providers.

1.4 The structure and content of these standards

The standards are in two parts:

Part 1: IET standards for pharmacists – learning outcomes

This part includes the knowledge, skills, understanding and professional behaviours a student pharmacist must demonstrate at the end of a course leading to registration with the GPhC. As part of this consultation we need to check that the learning outcomes are the right ones and we have asked a question about this.

Part 2: IET standards for pharmacists – standards for course providers

This part includes the requirements of a course delivering the learning outcomes in part 1. As part of this consultation we need to check that these standards are the right ones and we have asked a question about this.

Although they are for different audiences, the two parts are closely linked to each other. This is why they have been presented in one document.

Once the standards have been agreed we will issue guidance on them for course providers.

1.4.1 Part 1: IET standards for pharmacists – learning outcomes

Part 1 of these standards is presented as learning outcomes – that is the skills, knowledge, understanding and professional behaviours a student pharmacist must demonstrate at the end of their initial education and training. As a whole, these learning outcomes describe a student pharmacist who is fit to practise once registered.

We have grouped them under four 'domains', building on the three key themes in our consultation on the future pharmacy team (professionalism, communication and team working) and the standards for pharmacy professionals. The domains[2] are:

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

[2] These are the domains used in our standards for the initial education and training of pharmacy technicians.

4. Collaboration

Each of the four headings has been linked to a standard from our nine standards for pharmacy professionals, to show the link between IET and practice (see below).

The learning outcomes include the term ‘person-centred care’ and refer to a ‘person’, ‘individual’ or ‘people’ throughout. This means ‘the person receiving care’. However, although we do not always specifically refer to carers or patients’ representatives, these terms apply to them too depending on the context. This is consistent with our use of ‘person’ in our standards for pharmacy professionals.

Person-centred care			Professionalism		Professional knowledge and skills		Collaboration	
Person centred care	Effective communication	Respect for personal privacy and confidentiality	Professional behaviour	Professional judgement	Speaking up about concerns	Professional knowledge and skills	Partnership working	Effective leadership

1.4.2 Part 2: IET standards for pharmacists – standards for course providers

Part 2 of the standards focuses on the key features of courses that deliver the learning outcomes in part 1. Different models can be adopted to deliver the standards for the IET of pharmacists and so it is important to note that the standards have been written in such a way that they are not prescriptive about delivery.

As we did with part 1, we have grouped part 2 of the standards into domains:

1. Selection admission
2. Equality, diversity and fairness
3. Resources and capacity
4. Managing, developing and evaluating initial education and training
5. Curriculum design and delivery
6. Assessment
7. Support and development for student pharmacists and people delivering initial education and training
8. Learning in practice
9. Learning in practice supervision

In each domain there are one or more standards, followed by a number of criteria that have to be in place for a standard to be met.

Section 2: This section presents the text of the proposed standards

Standards for the initial education and training of pharmacists

Introduction

Pharmacy professionals play a vital role in ensuring public and patient safety by providing safe and effective care. Pharmacists have a vital role in delivering care and helping people to maintain and improve their health, safety and wellbeing. The safety of people is at the heart of these standards and must be central to the education and training of pharmacists across all learning environments. Public and patient safety is not a separate requirement – it is embedded in all these standards and criteria. Programme providers and employers must prioritise public and patient safety in all aspects of the course and its delivery.

These standards describe:

- the knowledge, skills, understanding and professional behaviours a student pharmacist must achieve during their initial education and training, and
- other aspects of the course they will take.

Once a student pharmacist has successfully completed their course they can apply for registration with the GPhC.

The structure of the standards

The standards for the initial education and training of pharmacists are in two parts:

1. Learning outcomes
2. Standards for course providers

Part 1, the learning outcomes, describes what a student pharmacist will be able to do on successful completion of their course. The learning outcomes are presented in four domains:

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

Part 2, the standards for course providers, describes the requirements for any course provider. The standards have nine domains:

Domain 1 – Selection admission

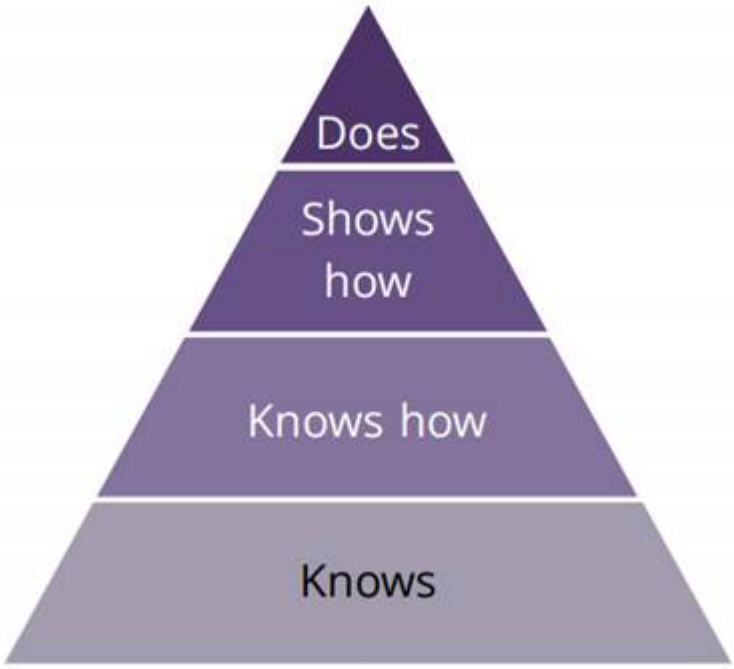
Domain 2 – Equality, diversity and fairness
Domain 3 – Resources and capacity
Domain 4 – Managing, developing and evaluating initial education and training
Domain 5 – Curriculum design and delivery
Domain 6 – Assessment
Domain 7 – Support and development for student pharmacists and people delivering initial education and training
Domain 8 – Learning in practice
Domain 9 – Learning in practice supervision

Part 1: Learning outcomes

Standard: On successful completion of their initial education and training, student pharmacists will have achieved the learning outcomes in these standards.

Describing and assessing outcomes

The outcome levels in this standard are based on an established competence and assessment hierarchy known as 'Miller's triangle':



Because what is being assessed at each of the four levels is different, the assessment methods needed are different too – although there will be some overlap.

Level 1 – Knows

This is knowledge that may be applied in the future to demonstrate competence. Assessments may include essays, oral examinations and multiple-choice question examinations (MCQs).

Level 2 – Knows how

Context-based tests – a student pharmacist knows how to use knowledge and skills. Assessments may include essays, oral examinations, MCQs and laboratory books.

Level 3 – Shows how

A student pharmacist is able to demonstrate that they can perform in a simulated environment or in real life. Assessments may include objective structured clinical examinations (OSCEs) and other observed assessments; simulated patient assessments; designing, carrying out and reporting an experiment; dispensing tests and taking a patient history.

Level 4 – Does

Acting independently and consistently in a complex but defined situation. Evidence for this level is provided when a student pharmacist demonstrates the learning outcomes in a complex, familiar or everyday situation repeatedly and reliably. Assessments may include OSCEs or other observed assessments.

Level of study

The level of study for MPharm degrees is Master's level, as defined in UK national qualifications frameworks.

Domains of study

The learning outcomes fall under four domains:

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

The domains and learning outcomes all have equal importance.

Introduction

These learning outcomes will develop pharmacists equipped to play an important role in providing clinical services to people while treating them with compassion and empathy, operating in multi-professional teams across healthcare settings aiming to increase patient safety and working towards improving the health and well-being of people.

In order to achieve this, courses delivering these learning outcomes will:

- focus on the role of the pharmacist as healthcare professional, using their comprehensive expertise of medicines, building on their strong grounding in science, to deliver high quality person-centred care,

- provide opportunities for inter-professional learning with students from other health professions and for experience in different sectors, and

- provide opportunities for student pharmacists to engage with patients and other healthcare professionals.

Pharmacy professionals play a vital role in ensuring public and patient safety by providing safe and effective care. The safety of people is at the heart of these learning outcomes and must be central to the education and training of student pharmacists across all learning environments.

Public and patient safety is embedded in all these learning outcomes. Course providers and employers must prioritise public and patient safety in all aspects of the course and its delivery.

Also embedded within these education learning outcomes are the standards for pharmacy professionals, which are the professional standards pharmacy students will be expected to meet, once they join the register.

Part 1: Learning outcomes

Domain 1: Person-centred care

Student pharmacists will be able to:

1.1 Work in partnership with patients, carers and the public to support and empower them when making decisions about their health and wellbeing – Does

1.2 Proactively support people with the safe and effective use of their medicines and devices – Does

1.3 Recognise equality and diversity and respect cultural and other differences, making sure that every person is treated fairly and with respect whatever their values, beliefs and needs – Does

1.4 Adapt approach and communication style to meet the needs of each person – Does

1.5 Take into consideration factors that affect people's behaviours in relation to health and wellbeing – Shows how

1.6 Take action to safeguard people, particularly children and vulnerable adults – Shows how

Domain 2: Professionalism

Student pharmacists will be able to:

2.1 Demonstrate the values, attitudes and behaviours expected from a pharmacist – Does

2.2 Recognise own future role as a responsible and accountable pharmacist who understands legal and ethical implications in all working environments – Does

2.3 Apply professional judgement in all circumstances – Does

2.4 Recognise and work within the limits of their knowledge and skills, seek support and refer to others when needed – Does

2.5 Engage effectively with local and national health policies to improve patient outcomes and public health – Does

2.6 Critically evaluate and utilise national guidance and clinical evidence to support safe, rational and cost-effective procurement and use of medicines and devices and services – Does

2.7 Take responsibility for accurate and safe work of self and others – Does

2.8 Take personal responsibility for health and safety of themselves and others, and take actions to address any concerns about the working environment which might put them, or others, at risk – Does

2.9 Recognise when their performance or the performance of others is putting people at risk and take appropriate actions – Shows how

2.10 Proactively engage in the management of risks and their impacts on individuals – Does

2.11 Take appropriate actions to respond to complaints, incidents or errors in a timely manner and to prevent them happening again – Does

2.12 Understand and address the importance of infection control and management in populations, environments and individuals – Shows how

2.13 Develop effective strategies to lead and improve quality in practice – Shows how

2.14 Reflect upon, identify and address own learning needs – Does

Domain 3: Professional knowledge and skills

Student pharmacists will be able to:

3.1 Understand and apply the science of pharmacy – Does

3.2 Take responsibility for the legal, safe and efficient supply of medicines and devices – Does

3.3 Demonstrate how the science of pharmacy is applied in the discovery, design and development of effective and safe medicines and devices – Shows how

3.4 Understand and demonstrate pharmaceutical principles to the safe and effective formulation, preparation, packaging and disposal of medicines and products – Shows how

3.5 Ensure quality of ingredients and medicines to produce and supply safe and effective medicines and products – Shows how

3.6 Understand and apply the principles of clinical therapeutics and medicines optimisation – Shows how

3.7 Recognise and apply the principles of pharmacovigilance – Does

3.8 Understand and perform pharmaceutical calculations to demonstrate safe and effective practice – Does

3.9 Use the evidence base to clinically and legally evaluate the most appropriate course of action for each individual person – Does

3.10 Critically evaluate the evidence base to improve practice and systems and the quality of care – Does

3.11 Engage in research activities and understand how research is applied to practice – Does

3.12 Identify and employ appropriate diagnostic or physiological testing techniques to inform clinical decision making – Does

3.13 Demonstrate effective consultation skills – Does

3.14 Demonstrate effective diagnostic skills to inform the most appropriate course of action – Does

3.15 Undertake safe and appropriate physical examination and use clinical skills to inform clinical decision making – Does

3.16 Apply the legal and professional requirements around the management of information and to ensure patient confidentiality – Does

3.17 Take responsibility for the legality, appropriateness and accuracy of records in all aspects of practice – Shows how

3.18 Use current technology and data to support the health of people by the safe and effective delivery of pharmaceutical services – Does

3.19 Proactively participate in the promotion and protection of public health in own practice – Does

3.20 Effectively promote healthy lifestyles utilising evidence based techniques and take appropriate actions – Does

3.21 Implement appropriate strategies in relation to the misuse of drugs – Does

3.22 Respond appropriately to medical emergencies, including provision of first aid – Does

Domain 4: Collaboration

Student pharmacists will be able to:

4.1 Work collaboratively with other healthcare professionals demonstrating clinical leadership where appropriate – Does

4.2 Communicate effectively with other health and social care professionals – Does

4.3 Manage resources and priorities, utilising the skills and knowledge of other members of the pharmacy team – Does

4.4 Demonstrate effective leadership, team working and management skills as part of the multi-disciplinary team – Does

4.5 Support in the learning and development of others including mentoring – Does

Part 2: Standards for the initial education and training of pharmacists

Part 2 is made up of the nine standards for course providers and their associated criteria.

Domain 1 – Selection and admission

Standard

Students must be selected and admitted at all stages of initial education and training on the basis that they are being prepared to practise as a pharmacist

Criteria to meet this standard

1.1. Selection processes must give applicants the guidance they need to make an informed application.

1.2. Selection criteria must be explicit. They must include:

a) meeting academic entry requirements;

b) meeting professional entry requirements, that is suitability to practise as a pharmacist;

c) meeting numeracy requirements;

d) meeting English language requirements appropriate to Masters level and for professional registration. Guidelines issued by English language testing bodies should be followed to ensure that admissions language requirements are appropriate;

e) taking account of good character checks;

f) taking account of health checks;

g) recognising prior learning, where that is appropriate.

1.3. When setting admissions criteria, account should be taken of admissions requirements for periods of learning in practice overseen by national health education bodies such as NHS Education Scotland, Health Education England and Health Education and Improvement Wales.

1.4. Admissions and selection must include a face-to-face component, in order to assess values and professional suitability. This can include Skype/Facetime sessions for applicants unable to attend admissions/selections events in person. This requirement includes clearing.

1.5. Where schools of pharmacy accept applicants who did not meet the academic entry requirements, they must set out clearly the criteria used for making these decisions.

1.6. Selectors must apply the selection criteria fairly and consistently. They must be trained to do this. Training must include equality and diversity awareness.

1.7. Annually, the course admissions profile must be analysed by protected characteristics, as defined in the Equality Act 2010, and documented action must be taken if that analysis shows that the admissions process may be disadvantaging students.

Domain 2 – Equality, diversity and fairness

Standard

Initial pharmacy education and training must be based on principles of equality, diversity and fairness and must be delivered in such a way that the diverse needs of all students are met

Criteria to meet this standard

2.1. Systems and policies must be in place for course providers to understand the diversity of their student body and to support and develop their students accordingly.

2.2. There must be systems and policies in place enabling staff to understand the diversity of the student body and the implications of that for course delivery.

2.3. There must be systems and policies in place enabling staff to understand the diversity of the student body and the implications of that for student support and development.

2.4. There must be an annual review of student performance by protected characteristics, as defined in the Equality Act 2010, and documented action must be taken to address differences where they are found.

Domain 3 – Resources and capacity

Standard

Resources and capacity must be sufficient to deliver the course's learning outcomes.

Criteria to meet this standard

3.1. There must be robust and transparent mechanisms for securing an appropriate level of resource for delivering a financeable, sustainable and accreditable degree.

3.2. The staff complement must be appropriate for the delivery of a degree forming part of the initial education and training of a pharmacist and must include a cadre of pharmacists able to lead the delivery of the professional practice components of the course.

3.3. The degree must be delivered in premises which are fit for purpose.

Domain 4 – Managing, developing and evaluating initial education and training

Standard

The quality of pharmacy education and training must be managed, evaluated and developed in a systematic way.

Criteria to meet this standard

4.1. There must be systems and policies in place to manage the delivery of the degree, including periods of learning in practice, where that is appropriate.

4.2. Systems must be clear about leadership and lines of responsibilities in relationship with the course.

4.3. Systems and policies must be used in such a way that the course is evaluated on the basis of evidence and that there is continuous improvement in its delivery.

4.4. Course providers must demonstrate how user views – particularly those of patients – have been used to develop the course.

4.5. Providers must have procedures to deal with concerns including fitness to practise procedures. Serious concerns that may affect a student pharmacist's suitability for future registration must be reported to the GPhC.

4.6. Course providers are open with the GPhC about matters affecting an accredited degree. It is a requirement of The Pharmacy Order 2010 that course providers assist the GPhC in its work by providing information on request.

4.7. Course providers raise relevant issues proactively with the GPhC.

Domain 5 - Curriculum design and delivery

Standard

The curriculum and learning in practice must develop the required skills, knowledge, understanding and professional behaviours to meet the outcomes in part 1 of these standards by using a coherent teaching and learning strategy. The design and delivery of training must take account of stakeholders' views and must ensure that student pharmacists practise safely and effectively.

Criteria to meet this standard

5.1. Curricula must integrate relevant science and practice and the component parts of the education and training must be linked in a coherent way. This must be progressive with increasing complexity until the appropriate level is reached.

5.2. There must be a teaching and learning strategy that sets out how student pharmacists will achieve the outcomes in part 1.

5.3. The course must be delivered in an environment which places study in a professional and academic context and requires students to conduct themselves professionally.

5.4. The course must be delivered in an environment informed by research.

5.5. Academic regulations must be appropriate for a degree that is both academic and professional and which may lead to further professional training. As a general principle, all assessments must be passed. This means that condonation, compensation, trailing, extended re-sit opportunities and other remedial measures should be extremely limited, if they are permitted at all. Academic regulations may be more stringent than university norms. This may include higher than usual pass marks for assessments demonstrating knowledge and skills essential to safe and effective pharmacy practice.

5.6. Student pharmacists must have exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competency to achieve the relevant learning outcomes in part 1 of these standards. This experience should be progressive and increase in complexity and take into consideration best practice.

5.7. Student pharmacists must engage with inter-professional education based on the C.A.I.P.E definition of learning from, with and about other healthcare professional to collaborate and improve care[3]. Engagement with students from other health and care professionals must begin at an early stage progressing to more complex interactions to enable them to develop the skills and level of competency to achieve the relevant learning outcomes in part 1 of these standards.

5.8. Providers must get the views of a range of stakeholders – including patients, the public and employers – and take into account of them when designing and delivering the course.

5.9. Curricula must be revised when there are significant changes in practice to ensure relevance and currency.

5.10. Students cannot receive an unaccredited degree if there are any outstanding student fitness to practise concerns about them.

Domain 6 – Assessment

Standard

Providers must demonstrate that they have a coherent assessment strategy which assesses required skills, knowledge, understanding and behaviours to meet the outcomes in part 1 of these standards. The assessment strategy must assess whether a student pharmacist's practice is safe.

Criteria to meet this standard

6.1. Providers must demonstrate they have a coherent assessment strategy which is fit for purpose and ensures that assessment is robust, valid and reliable and includes diagnostic, formative and summative assessment.

6.2. The assessment strategy must assess the outcomes in part 1 of these standards. The methods of assessment used must be appropriate to the learning outcomes, in line with current and best practice and be routinely monitored, quality assured and developed.

6.3. Assessment must be fair and undertaken against clear criteria. The standard expected of students in each area to be assessed must be clear and students and staff involved in assessment must be aware of this standard. An appropriate standard setting process must be employed for summative assessments.

6.4. Patient safety must come first at all times and must assess whether a student pharmacist is practicing safely.

[3] **CAIPE (2002) Interprofessional Education- Today, Yesterday and Tomorrow (Barr, H.) Higher Education Academy, Learning & Teaching Support Network for Health Sciences & Practice, Occasional Paper 1**

6.5. Pass criteria for all assessments must reflect safe and effective practice.

6.6. The provider must have in place effective management systems to plan, monitor and record the assessment of students, including the monitoring of clinical experience and inter-professional education, throughout the programme against each of the learning outcomes.

6.7. The provider must support students to improve their performance by providing regular and timely feedback and by encouraging students to reflect on their practice.

6.8. Assessment must utilise feedback collected from a variety of sources, which should include other members of the pharmacy team, peers, patients and employers/placement providers.

6.9. Examiners/assessors must have appropriate skills, experience and training to undertake the task of assessment. Examiners/assessors should have received training in equality and diversity relevant for their role.

6.10. Providers must ask external examiners to report on the extent to which assessment processes are rigorous, set at the correct standard, ensure equity of treatment for students and have been fairly conducted. The responsibilities of the external examiners must be clearly documented.

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

Domain 7 – Support and development for student pharmacists and people delivering initial education and training

Standard

Student pharmacists must be supported in all learning and training environments to develop as learners and professionals during their initial education and training.

Anyone delivering initial education and training should be supported to develop in their professional role.

Criteria for meeting this standard

Support for student pharmacists

7.1. There must be a range of systems in place across the institution to support student pharmacists to achieve the outcomes in part 1 of these standards, including:

a) Induction;

b) Effective supervision;

c) An appropriate and realistic workload;

d) Personal and academic support;

e) Time to learn;

f) Access to resources.

7.2. Students pharmacists must have support available to them covering academic, general welfare and career advice.

7.3. Student pharmacists must have access to pharmacy professionals who are able to act as role models and mentors, giving professional support and guidance.

7.4. There must be clear procedures for student pharmacists to raise concerns. Any concerns must be dealt with promptly, with documented action taken where appropriate.

Support for people involved in delivering initial education and training

7.5. There must be a range of mechanisms in place to support anyone delivering initial education and training to develop in their professional role.

7.6. Induction programmes are provided for people delivering initial education and training.

7.7. Everyone involved in delivering the curriculum must have:

a) Effective supervision

b) An appropriate and realistic workload

c) Mentoring

d) Time to learn

e) Continuing professional development opportunities

f) Peer support

7.8. There must be clear procedures for staff and individual to raise concerns. Any concerns must be dealt with promptly, with documented action taken where appropriate. Serious concerns about the course and impact on students must be actively raised with the GPhC.

Domain 8 – Learning in practice

NB 'Learning in practice' is currently known as 'pre-registration training'.

Standard

Learning in practice training must focus on the professional practice of pharmacists and must contribute to the delivery of the course's learning outcomes

Criteria to meet this standard

8.1. In total there must be 52 weeks of learning in practice.

8.2. The content of the learning outcomes for learning in practice must be defined by the course provider, in consultation with those delivering or quality assuring the learning in practice.

8.3. Training may take place in one or more sectors of practice.

8.4. 26 weeks must be patient-facing and must be positioned towards the end of the degree.

8.5. Learning in practice can be delivered in one or more blocks.

8.6. Each block does not have to be limited to one sector of practice.

8.7. Student pharmacists must follow a programme of study during periods of learning in practice.

8.8. Learning in practice blocks must be linked clearly to university study and must have a clear purpose within the degree overall.

Domain 9 – Learning in practice supervision

NB 'Learning in practice supervisors' are known, currently, as 'pre-registration tutors'.

Standard

Student pharmacists must be supervised by pharmacists and others during periods of learning in practice to help them meet the learning outcomes of periods of learning in practice

Criteria to meet this standard

9.1. Student pharmacists must have a designated learning in practice supervisor, who is responsible for co-ordinating their supervision and signing them off as being fit to practise at the end of the final period of learning in practice.

9.2. The designated learning in practice supervisor must know how and by whom a student pharmacist is being supervised during periods of learning in practice.

9.3. Student pharmacists can be supervised by pharmacists other than their designate learning in practice supervisor and by other health and social care professionals.

9.4. All supervisors must be trained and appropriately experienced to act as supervisors.

9.5. The designated learning in practice supervisor, or their delegates, must meet with a student pharmacist regularly during periods of learning in practice. Meetings must be developmental with documented outcomes.

9.6. If a designated learning in practice supervisor has concerns that a student pharmacist may be failing to meet the learning outcomes for training in practice, they must put an action plan in place.

9.7. Designated learning in practice supervisors must not sign off student pharmacists if they have not met the learning outcomes of learning in practice.

9.8. Designated learning in practice supervisors must not sign a student pharmacist's application to sit the General Pharmaceutical Council's Registration Assessment if they feel the student is not ready to sit.

The standards end here

Section 3: Responding to the consultation

How to respond to the consultation

You can respond to this consultation by going to www.pharmacyregulation.org/IETPstandards and filling in an online survey there.

Please contact us at consultations@ pharmacyregulation.org if you would like a copy of the survey in another format (for example, in hard copy, larger type or in a different language).

How we will use your responses

After the consultation, we will publish a report summarising what we heard.

If you respond as a private individual, we will not use your name or publish individuals' responses. If you respond on behalf of an organisation, we will list your organisation's name and may publish your response in full unless you tell us not to. If you want any part of your response to stay confidential, you should explain why you believe the information you have given is confidential. The GPhC may need to disclose information under the laws covering access to information (the General Data Protection Regulation 2016/679). If you ask us to keep part or all of your response confidential, we will treat this request seriously and try to respect it but we cannot guarantee that confidentiality can be maintained in all circumstances. If you email a response to the consultation and this is covered by an automatic confidentiality disclaimer generated by your IT system this will not, in itself, be binding on the GPhC.

Consultation questions

The consultation will focus on our proposed changes to the following aspects of the initial education and training of pharmacists:

- Learning outcomes
- Standards for course providers
- Integrating the five years of initial education and training
- Admission requirements
- Experiential learning and inter-professional learning
- Learning in practice supervision

There will be questions on each of these areas and you will have an opportunity to provide comments.

Section 1: Learning outcomes

As part of this revision of the initial education and training standards for pharmacists, we have developed a set of learning outcomes which should describe the right knowledge, skills and attributes of a pharmacist.

Q1: Considering the full set of **learning outcomes** in Part 1 of these draft initial education and training standards, to what extent do you agree or disagree that these are appropriate learning outcomes for a pharmacist?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don’t know

Q2: Is there anything in the **learning outcomes** that is missing or should be changed?

- Yes
- No
- Don’t know

Q3: Which of the following areas require additions and/or amendments?

(Please tick all that apply)

- Person-centred care
- Professionalism
- Professional knowledge and skills
- Collaboration

- Other (please state another area below)

Q4: Please give a brief description of the additions and/or amendments you have identified (if possible, please give the reference number of the learning outcomes).

Section 2: Standards for course providers

As part of this revision of the initial education and training standards for pharmacists, we have produced a set of standards for course providers detailed in Part 2. The standards describe the requirements for courses delivering the learning outcomes in Part 1.

Q5: Considering the full set of **standards and criteria** in Part 2, to what extent do you agree or disagree that these are appropriate for the initial education and training of pharmacists?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don’t know

Q6: Is there anything in the **standards or criteria** that is missing or should be changed?

- Yes
- No
- Don’t know

Q7: Which of the following areas require additions and/or amendments?

(Please tick all that apply)

- Domain 1 – Selection and admission
- Domain 2 – Equality, diversity and fairness
- Domain 3 – Resources and capacity
- Domain 4 – Managing, developing and evaluating initial education and training
- Domain 5 – Curriculum design and delivery
- Domain 6 – Assessment
- Domain 7 – Support and development for student pharmacists and people delivering initial education and training
- Domain 8 – Learning in practice
- Domain 9 – Learning in practice supervision

Q8: Please give a brief description of the additions and/or amendments you have identified.

Please note that you have the possibility to provide comments on admission requirements, experiential learning, inter-professional learning and learning in practice supervision later in the consultation.

Section 3: Integrating the five years of initial education and training

These standards have a greater focus on clinical skills, on communicating with patients and working effectively with other health and care professionals. Student pharmacists need exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competence required to be prepared for their future roles as pharmacists. This requires a much stronger link between the currently separate elements of academic study in the MPharm degree and workplace experience contained in the pre-registration year. We therefore propose a closer integration of study and practical learning and to set the learning outcomes to be achieved over five years in order to adequality prepare student pharmacists for their future roles.

Q9: Do you agree or disagree that we should set standards for the five years of education and training?

- Agree
- Disagree
- Don’t know

Q10: Please explain your response

Section 4: Admission requirements

We propose to strengthen the admission requirements in the standard by requiring course providers to assess the **values** of prospective students in addition to their academic qualifications in order to assess professional suitability. With the increased focus on patient-centred care in our proposed learning outcomes, this additional requirement will ensure course providers are thinking more widely about the all-round abilities of prospective students and their suitability to become pharmacists.

Q11: Do you agree or disagree with our proposal to require schools of pharmacy to assess the values of prospective students as part of their admission procedures?

- Agree
- Disagree
- Don’t know

Q12: Please explain your response

To help schools of pharmacy to assess the **values** of prospective students, we will also introduce a mandatory requirement to conduct face-to-face interviews with prospective students as part of the admission process. In addition to informing an assessment of values, it also enables course providers to assess the overall communication skills of prospective students in line with the greater focus on this element within the learning outcomes. This requirement would apply to all MPharm admissions, including those students seeking admission to a university through clearing.

Q13: Do you agree or disagree with our proposal to make a face-to-face element mandatory in schools of pharmacy admission procedures?

- Agree
- Disagree
- Don’t know

Q14: Please explain your response

We have noted the wider trend of students entering university having not achieved the advertised grades. That raises the question of whether our standards should be more prescriptive and require course providers to admit only those students who have demonstrated their academic ability by achieving the A level/Highers grades advertised for a course. While there are some arguments in favour of this, we are very conscious of the aim to widen opportunity of access to university and healthcare professions. We are also aware that students who may not have achieved the advertised grades may nevertheless with the right support, application and values, succeed over the course of their education and training. We therefore need to balance a high standard of admissions with ensuring widening opportunities.

Q15: In order to achieve this, should we be more prescriptive about academic admission requirements?

- Yes
- No
- Don’t know

Q16: Please explain your response

Q17: To what extent do you agree or disagree that the admission requirements can be measured effectively?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don’t know

Q18: Please explain your response

Section 5: Experiential learning and inter-professional learning

We are concerned that there may be too much variability in the amount of experiential learning and of inter-professional learning with other healthcare profession students in MPharm degrees. To ensure greater consistency, we propose to that student pharmacists must have exposure to an appropriate breadth of patients and people in a range of environments (real and simulated) to enable them to develop the skills and the level of competency to achieve the relevant learning outcomes in Part 1 of

these standards. Our revised standards also state that student pharmacists must participate in inter-professional learning. Engagement with students from other health and care professionals must begin at an early stage progressing to more complex interactions to enable them to develop the skills and level of competency to achieve the relevant learning outcomes in Part 1 of these standards.

Q19: Do you agree or disagree with our proposals in regard to:

Experiential learning (practical learning)?

- Agree
- Disagree
- Don't know

Inter-professional learning?

- Agree
- Disagree
- Don't know

Q20: Please explain your response

Section 6: Learning in practice supervision

We are proposing to make several changes to what is currently known as pre-registration training, which we are planning to rename learning in practice. The first is to supplement the current four tutor signoffs with more regular progress meetings, which must be documented. We propose that there should be a minimum of six progress meetings.

Q21: Do you agree or disagree with our proposal to replace the current four tutor signoffs with a minimum of six regular progress meetings between tutors and student pharmacists?

- Agree
- Disagree
- Don't know

Q22: Please explain your response

The second change to learning in practice is that we plan to withdraw the current pre-registration performance standards and replace them with the learning outcomes in these standards. The pre-registration performance standards date from 1993 and are no longer fit for purpose.

Q23: Do you agree or disagree with our proposal to replace the current pre-registration performance standards with the learning outcomes stated in Part 1 of the revised standards?

- Agree
- Disagree

- Don’t know

Q24: Please explain your response

Section 7: Impact of the standards

Q25: We want to understand whether our proposals may discriminate against or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below?

(Please tick all that apply)

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- None of the above

Q26: We also want to understand whether our proposals may benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below?

(Please tick all that apply)

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- None of the above

Q27: Please describe the impact and the individuals or groups concerned identified in questions 25 and 26.

Q28: Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups? For example, student pharmacists, patients and the public, schools of pharmacy, learning in practice providers, pharmacy staff, employers.

- Yes
- No
- Don't know

Q29: Please describe the impact and the individuals or groups concerned.

Equality monitoring

The equality monitoring form will be added here.

Appendix A: Collated consultation questions

Section 1: Learning outcomes

Q1: Considering the full set of **learning outcomes** in Part 1 of these draft initial education and training standards, to what extent do you agree or disagree that these are appropriate learning outcomes for a pharmacist?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Q2: Is there anything in the **learning outcomes** that is missing or should be changed?

- Yes
- No
- Don't know

Q3: Which of the following areas require additions and/or amendments?

(Please tick all that apply)

- Person-centred care
- Professionalism
- Professional knowledge and skills
- Collaboration
- Other (please state another area below)

Q4: Please give a brief description of the additions and/or amendments you have identified (if possible, please give the reference number of the learning outcomes).

Section 2: Standards for course providers

Q5: Considering the full set of **standards and criteria** in Part 2, to what extent do you agree or disagree that these are appropriate for the initial education and training of pharmacists?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don't know

Q6: Is there anything in the **standards or criteria** that is missing or should be changed?

- Yes
- No
- Don't know

Q7: Which of the following areas require additions and/or amendments?

(Please tick all that apply)

- Domain 1 – Selection and admission
- Domain 2 – Equality, diversity and fairness
- Domain 3 – Resources and capacity
- Domain 4 – Managing, developing and evaluating initial education and training
- Domain 5 – Curriculum design and delivery
- Domain 6 – Assessment
- Domain 7 – Support and development for student pharmacists and people delivering initial education and training
- Domain 8 – Learning in practice
- Domain 9 – Learning in practice supervision

Q8: Please give a brief description of the additions and/or amendments you have identified.

Please note that you have the possibility to provide comments on admission requirements, experiential learning, inter-professional learning and learning in practice supervision later in the consultation.

Section 3: Integrating the five years of initial education and training

Q9: Do you agree or disagree that we should set standards for the five years of education and training?

- Agree
- Disagree
- Don't know

Q10: Please explain your response

Section 4: Admission requirements

Q11: Do you agree or disagree with our proposal to require schools of pharmacy to assess the values of prospective students as part of their admission procedures?

- Agree
- Disagree
- Don't know

Q12: Please explain your response

Q13: Do you agree or disagree with our proposal to make a face-to-face element mandatory in schools of pharmacy admission procedures?

- Agree
- Disagree
- Don’t know

Q14: Please explain your response

Q15: In order to achieve this, should we be more prescriptive about academic admission requirements?

- Yes
- No
- Don’t know

Q16: Please explain your response

Q17: To what extent do you agree or disagree that the admissions requirements can be measured effectively?

- Strongly agree
- Tend to agree
- Neither agree nor disagree
- Tend to disagree
- Strongly disagree
- Don’t know

Q18: Please explain your response

Section 5: Experiential learning and inter-professional learning

Q19: Do you agree or disagree with our proposals in regard to:

Experiential learning (practical learning)?

- Agree
- Disagree
- Don’t know

Inter-professional learning?

- Agree
- Disagree

- Don’t know

Q20: Please explain your response

Section 6: Learning in practice supervision

Q21: Do you agree or disagree with our proposal to replace the current four tutor signoffs with a minimum of six regular progress meetings between tutors and student pharmacists?

- Agree
- Disagree
- Don’t know

Q22: Please explain your response

Q23: Do you agree or disagree with our proposal to replace the current pre-registration performance standards with the learning outcomes stated in Part 1 of the revised standards?

- Agree
- Disagree
- Don’t know

Q24: Please explain your response

Section 7: Impact of the standards

Q25: We want to understand whether our proposals may discriminate against or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below?

(Please tick all that apply)

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- None of the above

Q26: We also want to understand whether our proposals may benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Do you think our proposals will have a positive impact on certain individuals or groups who share any of the protected characteristics listed below?

(Please tick all that apply)

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- None of the above

Q27: Please describe the impact and the individuals or groups concerned identified in questions 25 and 26.

Q28: Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups? For example, student pharmacists, patients and the public, schools of pharmacy, learning in practice providers, pharmacy staff, employers.

- Yes
- No
- Don't know

Q29: Please describe the impact and the individuals or groups concerned.

Appendix B: Prescribing learning outcomes

One of the expert groups we convened as part of our pre-consultation engagement activities focused on prescribing. Part of the group's work included identifying which of the learning outcomes are relevant for prescribing.

Domain 1: Person-centred care

Student pharmacists will be able to:

1.1 Work in partnership with patients, carers and the public to support and empower them when making decisions about their health and wellbeing

1.2 Proactively support people with the safe and effective use of their medicines and devices

1.3 Recognise equality and diversity and respect cultural and other differences, making sure that every person is treated fairly and with respect whatever their values, beliefs and needs

1.4 Adapt approach and communication style to meet the needs of each person

1.5 Take into consideration factors that affect people's behaviours in relation to health and wellbeing

Domain 2: Professionalism

Student pharmacists will be able to:

2.1 Demonstrate the values, attitudes and behaviours expected from a pharmacist

2.2 Recognise own future role as responsible and accountable pharmacist who understands legal and ethical implications in all working environments

2.3 Apply professional judgement in all circumstances

2.4 Recognise and work within the limits of their knowledge and skills, seek support and refer to others when needed

2.5 Engage effectively with local and national health policies to improve patient outcomes and public health

2.6 Critically evaluate and utilise national guidance and clinical evidence to support safe, rational and cost-effective procurement and use of medicines and devices and services

2.7 Take responsibility for accurate and safe work of self and others

2.8 Take personal responsibility for health and safety of themselves and others, and take actions to address any concerns about the working environment which might put them, or others, at risk

2.9 Recognise when their performance or the performance others is putting people at risk and take appropriate actions

2.10 Proactively engage in the management of risks and their impacts on individuals

2.11 Take appropriate actions to respond to complaints, incidents, errors in a timely manner and to prevent them happening again

2.12 Understand and address the importance of infection control and management in populations, environments and individuals

2.13 Develop effective strategies to lead and improve quality in practice

Domain 3: Professional knowledge and skills

Student pharmacists will be able to:

3.1 Understand and apply the science of pharmacy

3.6 Understand and apply the principles of clinical therapeutics and medicines optimisation

3.7 Recognise and apply the principles of pharmacovigilance

3.8 Understand and perform pharmaceutical calculations to demonstrate safe and effective practice

3.9 Use the evidence base to clinically and legally evaluate the most appropriate course of action for each individual person

3.10 Critically evaluate the evidence base to improve practice and systems and the quality of care

3.11 Engage in research activities and understands how research is applied to practice

3.12 Identify and employ appropriate diagnostic or physiological testing techniques to inform clinical decision making

3.13 Demonstrate effective consultation skills

3.14 Demonstrate effective diagnostic skills to inform the most appropriate course of action

3.15 Undertake safe and appropriate physical examination and use clinical skills to inform clinical decision making

3.16 Apply the legal and professional requirements around the management of information and to ensure patient confidentiality

3.17 Take responsibility for the legality, appropriateness and accuracy of records in all aspects of practice

3.18 Use current technology and data to support the health of people by the safe and effective delivery of pharmaceutical services

3.19 Proactively participate in the promotion and protection of public health in own practice

3.20 Effectively promote healthy lifestyles utilising evidence based techniques and take appropriate actions

3.21 Implement appropriate strategies in relation to the misuse of drugs

3.22 Respond appropriately to medical emergencies, including provision of first aid

Domain 4: Collaboration

Student pharmacists will be able to:

4.2 Communicate effectively with other health and social care professionals

4.4 Demonstrate effective leadership, team working and management skills as part of the multi-disciplinary team

Meeting paper

Council on Thursday, 08 November 2018

Public business

Revalidation: 2019-2020 submissions and standards for pharmacy professionals

Purpose

To agree the standards for pharmacy professionals that registrants will be able to select from to produce their reflective accounts for 2019-2020 submissions for revalidation.

Recommendations

The council is asked to agree the three standards for pharmacy professionals that registrants will be directed to provide reflective accounts upon in the 2019-20 cycle of revalidation. The proposed standards are:

- Standard three - Pharmacy professionals must communicate effectively
- Standard eight - Pharmacy professionals must speak up when they have concerns or when things go wrong
- Standard nine - Pharmacy professionals must demonstrate leadership

1. Introduction

1.1. The **revalidation framework** has now been agreed by Council at its **meeting in December 2017** following a public consultation on draft proposals.

1.2. Part of the revalidation framework includes a reflective account on the **standards for pharmacy professionals** to be produced each year by registrants.

1.3. Each year of revalidation will focus on three different standards, one or more of which registrants can choose to provide a reflection upon using one or more examples from their practice.

1.4. The first year of revalidation submissions (31st October 2018 to 14th October 2019 renewal deadlines) does not require submission of a reflective account, in line with the overarching principle of revalidation's development and implementation to phase its roll out.

1.5. The second year of revalidation submissions (31st October 2019 to 14th October 2020 renewal deadlines) will be the first year that submission of a reflection account will be required.

1.6. Each year, the Council will decide which three standards reflective accounts should be based upon. The Council can take into consideration issues affecting pharmacy practice, the healthcare sector more broadly and in future data from previous revalidation cycles to inform their decision-making.

1.7. This paper sets out proposals for the three standards for the first year that registrants will be required to submit a record of a reflective account.

1.8. The next three sections of the paper outline the standards for pharmacy professionals which are proposed for the reflective account along with associated guidance and the rationale for their selection.

2. Standard three - Pharmacy professionals must communicate effectively

2.1. Associated guidance for the standard:

Applying the standard

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

People receive safe and effective care when pharmacy professionals:

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

2.2. This standard is proposed because:

- Effective communication is critical to safe and effective practice and we would like to offer the public reassurance that pharmacy professionals are reflecting upon this important set of skills.
- We used this standard in our pilot of revalidation for pharmacy professionals and we would like to compare how people respond now that more people will be providing reflections. This is part of our plan to evaluate revalidation for pharmacy professionals over time to improve it iteratively.
- This standard also encourages reflection across all three standards in the reflective account because communicating effectively will be indispensable in speaking up about concerns and demonstrating leadership.

3. Standard eight - Pharmacy professionals must speak up when they have concerns or when things go wrong

3.1. Associated guidance for the standard:

Applying the standard

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

People receive safe and effective care when pharmacy professionals:

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

3.2. This standard is proposed because:

- There have been repeated high profile cases in healthcare but outside of pharmacy where it appears that health professionals did not feel able to speak up about legitimate concerns they held about the practice of others or within a health setting. We would like everyone on our register to reflect upon this standard to provide assurance to the public that pharmacy professionals understand their responsibilities and how to effectively speak up to drive improvement and respond to concerns.
- This standard also encourages reflection across all three standards in the reflective account because speaking up about concerns will depend on communicating effectively and demonstrating leadership.

4. Standard nine - Pharmacy professionals must demonstrate leadership

4.1. Associated guidance for the standard:

Applying the standard

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

People receive safe and effective care when pharmacy professionals:

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

4.2. This standard is proposed because:

- Pharmacy professionals, both pharmacists and pharmacy technicians, regularly act as leaders in the course of their work as experts in medicines and medicines

management. We want to encourage pharmacy professionals to see themselves as part of a distributed leadership model, where everyone takes responsibility and leads by example. We want pharmacy professionals to reflect on how they have acted as leaders so that we can assure the public that pharmacy professionals understand their responsibilities as leaders and the benefit this has for patients and other service users.

- This standard also encourages reflection across all three standards in the reflective account because demonstrating leadership will depend on communicating effectively and would might include speaking up about areas of concern or improvement to reduce risks.

5. Equality and diversity implications

5.1. Equality and diversity implications for revalidation for pharmacy professionals have been considered throughout the development and implementation period through multiple analyses.

5.2. Relevant to this decision is the analysis from the pilot study presented to Council prior to consultation on the framework which indicated there were no significant barriers to engagement with the reflective account based on protected characteristics. Some data suggested that pharmacy technicians may be less likely to engage with the pilot study. We continue to work with with pharmacy technician representative bodies and training organisations to provide support where it is required. We have also produced a significant amount of additional supporting materials which has been tailored to different types of pharmacy professional. Additional data from myGPhC which is recording initial sign up and submission rates also suggests there is no difference between engagement from pharmacists and pharmacy technicians.

5.3. Also relevant is the work done to ensure myGphC, the online portal through which registrants will record and submit their reflective accounts is accessible. This work included testing with a diverse range of registrants over multiple stages of system design and an independent accessibility review.

6. Communications

6.1. We will communicate the standards upon which reflective accounts must be based from November 2018 in our newsletter Regulate, on our website, in direct communications to our registrants, and through the network of organisations supporting registrants with revalidation for pharmacy professionals.

7. Resource implications

7.1. The resource implications of this decision have already been accounted for in planning for operations of revalidation.

7.2. Further, communications costs have been kept to a minimum by using communications channels that are already in place.

8. Risk implications

8.1. There are very limited risk implications for this decision from Council because the wider risks related to revalidation are not impacted by the selection of the three standards for the reflective account.

8.2. Routine risk management processes are in place for revalidation and its implementation.

9. Monitoring and review

9.1. Revalidation submissions will provide an opportunity to review how effective the reflective account is as a tool to drive positive professional behaviours. Each year, analysis of the way in which registrants are engaging with the requirements for revalidation will provide useful insight to feed into review of policy and process.

9.2. Each year the Council will review and decide upon the standards for the next cycle of revalidation submissions and can take into consideration information drawn from the previous cycle.

Recommendations

The council is asked to agree the three standards for pharmacy professionals for which registrants will be directed to provide reflective accounts in the 2019-20 cycle of revalidation. The proposed standards are:

- Standard three - Pharmacy professionals must communicate effectively
- Standard eight - Pharmacy professionals must speak up when they have concerns or when things go wrong
- Standard nine - Pharmacy professionals must demonstrate leadership

Osama Ammar, Head of Revalidation
General Pharmaceutical Council

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30 October 2019

Meeting paper

Council on Thursday, 8 November 2018

Public business

Policy and procedure review

Purpose

To seek Council's approval for the policies and procedures within its remit that have been reviewed recently.

Recommendations

The Council is asked to approve:

i. the updated Terms of Reference for the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG)

ii. the updated Appointment of members of the Audit & Risk and Remuneration Committees policy

iii. the updated Raising Concerns policy

iv. the updated Anti-Bribery policy

v. the adoption of the Non-Staff Expenses Policy by Council members

1. Introduction

1.1. Authority in a number of policy areas is reserved to the Council within the Scheme of Delegation. This paper presents a review of a number of those policies and documents and asks the Council to approve minor updates and amendments.

1.2. Our policies and procedures are reviewed on a regular basis to ensure that they remain fit for purpose and in line with relevant legislation and other good practice guidance. The policies updated in this round have been set out below alongside a brief summary of the proposed amendments. These amendments have been agreed by the relevant Committees and are recommended to the Council for approval.

1.3. The updated policies and procedures are attached at Appendices 1 – 5.

2. Summary of updates

(a) EEAAG Terms of Reference

2.1. At its meeting on 11 September 2018, the EEAAG reviewed its current terms of reference and recommended a revised version to the Council for approval. This reflects the updated status of the group, particularly recognising its role in providing assurance directly to the Council on matters within its remit. Where appropriate, the terms of reference mirror those of the Audit & Risk and Remuneration Committees, to ensure broad consistency of approach across all three groups. Although current EEAAG membership does not include an external member, the terms have been adjusted to allow for this in the future, where necessary.

(b) Appointment of members of the Audit & Risk and Remuneration Committee

2.2. The scope of this policy has been extended to include the appointment of members of the EEAAG. This is to ensure that we take a consistent approach to appointments across all three groups. A minor amendment has also been made to remove out of date language relating to data protection in light of recent changes.

(c) Raising Concerns policy

2.3. The Audit and Risk Committee considered the current raising concerns policy at its meeting on 23 October 2018. As part of the review, we considered a range of similar policies from within the healthcare regulation sector and beyond, as well as the most up to date *Guidance for Employers and Code of Practice* issued by the Department for Business Innovation and Skills. A number of minor changes were made to the policy, including emphasising how people are encouraged to speak up when they have concerns and the wider link to our culture. For completeness, we have also added a brief summary of the protections available under the Public Interest Disclosure Act (PIDA) 1998 as well as a new flow chart in the appendix to set out the decision-making process. The Chair of EEAAG has also been added to the list of contacts who may assist in cases where the matter cannot be raised with management.

(d) Anti-bribery policy

2.4. The Audit and Risk Committee considered the current policy at its July meeting. As part of the review, our in-house legal team considered the policy to ensure that it remains up to date and in line with the current legislative framework. Additionally, we asked the Director of Anti-Fraud and Corruption at Moore Stephens to review the policy, to ensure that its remains fit for purpose and reflects current best practice. Overall, it was felt that the policy is succinct and covers all bases. However, a number of minor updates have been made to improve clarity and to include references to other relevant, supporting policies.

(e) Non-Staff expenses policy

The Remuneration Committee considered the non-staff expenses policy at its meeting on 27 September. The policy has been updated to remove the option to claim for additional travel tickets or amendment costs when the business ends three or more hours earlier than planned. The Committee also agreed similar amendments to the staff expenses policy and recommended these to the Chief Executive and Registrar for approval.

Other wider issues

2.5. Through the review of the Raising Concerns policy, the Audit and Risk Committee has asked the team to consider the idea of having a specific Freedom to Speak Up champion or guardian role for the organisation), to drive the commitment to valuing whistleblowing and supporting those raising concerns within the organisation.

2.6. We know that similar roles exist in the wider healthcare sector, including a network of Freedom to Speak Up Guardians within the National Guardian's Office. The Office supports the National Guardian for the NHS, Dr Henrietta Hughes, in providing leadership, training and advice for Freedom to Speak Up Guardians based in all NHS trusts and provides challenge, learning and support to the healthcare system as a whole by reviewing trusts' speaking up culture and the handling of concerns where they have not followed good practice. This role was a key recommendation from Sir Robert Francis' Freedom to Speak Up Review in response to the Mid-Staffordshire scandal.

2.7. In light of more recent reports such as the Report of the Gosport Independent Panel and the PSA Lessons Learned Report, it seems timely and important to explore the opportunities for a similar Freedom to Speak Up role within the GPhC and perhaps more broadly within the healthcare regulators themselves.

2.8. We are taking forward some exploratory work to consider the potential purpose and scope of this type of role within healthcare regulation. The role would not be a substitute for raising concerns through the appropriate channel, but to work proactively to support a positive speaking up culture throughout an organisation and support learning and improvement. In the future, data could also be collected and used to develop insights on how speaking up arrangements are working within and across healthcare regulators.

3. Equality and diversity implications

3.1. Equality and diversity implications have been considered in the development of individual policies.

3.2. When exploring options for a Freedom to Speak Up role, we will also ensure that equality and diversity aspects are taken into account, including important learnings and insights from the National Guardian's Office. For example, the 2017 Freedom to Speak Up Guardian

Survey recommended that all trusts take action to ensure that all workers, irrespective of diversity characteristics, have someone they feel able to go to for support in speaking up. The report also encouraged guardians to forge close working partnerships with staff diversity networks and consider recruiting and training members of these groups as champions / ambassadors, or developing some other means of partnership working so that the trust has the assurance that all workers feel supported and able to speak up.

4. Communications

4.1. Subject to approval by the Council, we will publish the updated policies on our intranet and raise awareness through a variety of mechanisms including culture workshops, staff induction processes and through the Capsule - our all staff e-newsletter. Where relevant, policies will also be published on our website. Policies affecting non-staff will also be shared through the relevant channels.

5. Resource implications

5.1. There are no specific resource considerations associated with the policy and procedure review. Further exploration of options for a Freedom to Speak Up role will include consideration of likely or potential resource implications.

6. Risk implications

6.1. It is essential that our range or policies and procedures are fit for purpose and reflect current legislation or other good practice guidance. It is also vital that policies are clear and published in an accessible format, so that people understand their responsibilities and what they can expect from the organisation.

7. Monitoring and review

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

Recommendations

The Council is asked to approve:

I. the updated Terms of Reference for the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG)

II. the updated Appointment of members of the Audit & Risk and Remuneration Committees policy

III. the updated Raising Concerns policy

IV. the updated Anti-Bribery policy

V. the adoption of the Non-Staff Expenses Policy by Council members

Laura McClintock, Chief of Staff
General Pharmaceutical Council

laura.mcclintock@pharmacyregulation.org

Tel 020 3713 8079

Terms of reference of the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG)

Effective from November 2018

1. Constitution

1.1 The Council has established the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG) to provide the Council with assurance on the continuing efficiency and effectiveness of the organisation.

1.2 The group's primary activities will be to:

i. Review the organisation's ongoing work to improve the efficiency and effectiveness of the GPhC

ii. Review the organisation's strategic and financial planning

iii. Review the management's work to ensure that efficiency and effectiveness become embedded with the GPhC's culture and to develop appropriate metrics, evaluation and benchmarking to ensure the ongoing delivery of efficiency and effectiveness

iv. Advise the senior leadership group as to matters within the EEAAG's remit

v. Report to Council as to the assurance provided by the review work undertaken in relation to i-iii above.

2. Definitions

2.1 The group will use the following agreed definitions in its work:

i. **Efficiency** - working in the best way possible getting the most out of the time, effort and resource we put in

ii. **Effectiveness** – doing the right things well to achieve our strategic plan and outcomes

3. Accountability and reporting

3.1 The group is accountable to the Council. The minutes of each EEAAG meeting shall be circulated to Council in confidential business. The group shall report to the Council annually on its work.

4. Membership

4.1 The group shall have five members, but may operate with fewer while a vacancy exists, provided the quorum is maintained. The group members shall include Council members, excluding the GPhC Chair, and include at least one lay member and one registrant member. The group may also include one external member with appropriate skills and experience.

4.2 The Council will appoint one of the Council members serving on the group as Chair, based on relevant background and skills. In the absence of the Chair, the group shall elect another of its members to chair the meeting.

4.3 The group, including its Chair, is appointed through arrangements agreed by the Council. This will be carried out in line with the Appointment of members of the non-statutory committees (Audit & Risk, Remuneration Committees and the Efficiency and Effectiveness Assurance and Advisory Group) policy (reference XXXX).

5. Quorum

5.1 The group will be quorate with two members of Council.

6. Attendance

6.1 Only members shall be entitled to attend the meetings of the group. The Chief Executive & Registrar shall normally attend the meetings along with key members of staff, as necessary.

6.2 The Council Chair and other Council members may attend meetings at the invitation of, or with the agreement of, the Chair of the Group.

6.3 The Group may request any employee or member to attend a meeting to assist with its discussions on any particular matter or to provide any information it may reasonably require in order to fulfil its remit. All employees and members are directed to co-operate with any reasonable request made by the Group.

6.4 The Group may ask any or all non-members to withdraw for all or part of a meeting if it so decides. In such an instance, the Chair shall ensure that a proper record is made of the meeting.

7. Secretariat

7.1 The Head of Governance shall ensure that appropriate secretariat support is provided to the Chair and to the Group.

8. Frequency of meetings

8.1 The group shall meet not less than four times a year.

9. Dealing with concerns

9.1 Processes have been agreed by Council for raising concerns (Raising concerns policy ref: XXXX)

9.2 Within these processes, the Chair of the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG) is identified as a point of contact for individuals who still have concerns having followed the policy or where they feel matter is so serious that is cannot be discussed by senior management.

9.3 Further information on how matters are handled is detailed within the Raising Concerns policy. The Chair of EEAAG will receive appropriate training in this area.

Policy author:	Duncan Rudkin
Job title:	Chief Executive & Registrar
Policy reference:	GPhCXXXX
Effective from:	01 November 2018
Review date:	XX November 2021
Agreed by:	Council on XX November 2018

Appointment of members of the non-statutory committees (Audit & Risk and Remuneration Committees and the Efficiency and Effectiveness Assurance and Advisory Group)

Effective from November 2018

1. Introduction and purpose

1.1 The following procedures should be used for the appointment of all members (i.e. Council members, external members and chairs) of the Council's non-statutory committees: the Audit & Risk and Remuneration committees and the Efficiency and Effectiveness Assurance and Advisory Group. This includes appointments to fill casual vacancies.

1.2 This procedure has been designed to ensure that a consistent approach is used when appointing members and Chairs to committees.

2. Appointment of Council members

2.1 Members of committees who are Council members, including the chairs of committees, shall be appointed by the Council.

2.2 Six months before the end of a committee member's existing appointment, the Governance Manager will invite members to indicate whether they wish to be considered for reappointment. The Governance Manager will also invite expressions of interest from other Council members.

2.3 Members of Council may signal their willingness to be appointed or re-appointed to a committee as a member or as chair by submitting a statement of up to 200 words in support to the Chair of the Council.

2.4 The Chair will take soundings from a lay and a registrant Council member then recommend members for appointment by the Council.

2.5 The Council will appoint a member to fill the vacancy based on all relevant information available, including any other expressions of interest and the balance to be achieved between retaining knowledge and bringing in new ideas.

2.6 If it is felt desirable to appoint a non-Council member as chair of the Remuneration Committee, the procedure below for appointing external members to the committees should be followed.

3. Appointment of external members to the committees

3.1 A panel comprising the GPhC Chair, one registrant Council member and one lay Council member will be formed when a vacancy exists or is anticipated. The Chair will invite Council members to join the panel based on expressions of interest.

3.2 The appointments panel will appoint non-Council members to the Audit & Risk and Remuneration Committees, and the Efficiency and Effectiveness Assurance Group, following the procedure at Appendix 1. This procedure has been designed to ensure that a consistent approach is used when appointing external members to committees. However, ultimate responsibility for making these appointments rests with the appointments panel.

3.3 This procedure applies to the Council, all appointments panels, and all staff involved with the process including the Head of Governance and the Governance Manager.

Policy author:	Laura McClintock
Job title:	Chief of Staff
Policy reference:	XXXXXX
Effective from:	XX November 2018
Review date:	XX November 2021
Agreed by:	Council on XX November 2018

Appendix 1: Procedure for appointing external members to committees

1. General Principles

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

1.2 Although these appointments do not come within the remit of the Commissioner for Public Appointments, the procedures take into account the Commissioner's Code of Practice.

2. The appointments process – planning

2.1 The Governance Manager should monitor membership of committees for forthcoming vacancies since vacancies can take some time to fill. Six months before the end of a committee member's existing appointment, the Governance Manager will invite members to indicate whether they wish to be considered for reappointment.

2.2 If so, the external member's most recent appraisal will be sent to the panel. The panel will also take soundings from the relevant committee chair on the desirability of continuity or recruitment of a new external member. The panel will then decide whether to re-appoint or to recruit a new external member to fill the vacancy based on all relevant information available, including the balance to be achieved between retaining knowledge and bringing in new ideas.

2.3 If the panel decides to recruit a new external member, the Governance Manager should produce a role description and person specification for every new appointment, for sign off by the appointments panel. The person specification should set out the experience, personal qualities, professional qualifications (if appropriate) and competencies against which applications will be assessed.

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

3. The appointments process – planning

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

3.2 Information packs will be made available for download from the website.

3.3 Applicants will be required to provide information on any potential conflicts of interest.

3.4 Applications will be accepted in the manner and time agreed by the appointments panel, which may include the use of an application form if considered desirable

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

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

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

4. The appointments process – selection

4.1 Candidates will be interviewed by the appointments panel.

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

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

4.4 GPhC staff will provide an evaluation form for use by interviewers. Interviewers shall make a note of the key interview performance points that influenced them. The appointments panel chair shall keep a clear and objective record of the panel's rating of each candidate and agreed decision. Each member of the panel should sign the agreed panel summary for each candidate.

4.5 Selection of the most suitable candidate for the appointment should only be made on merit on the basis of information provided by them in their applications forms and at interview.

5. Post-selection procedure

5.1 When a decision has been made, all candidates should be notified in writing with the minimum of delay.

5.2 Under the Data Protection Act 2018 and General Data Protection Regulation, candidates may request feedback on interview performance or an account of the process undertaken. Such requests will be dealt with promptly by a member of GPhC staff, using the appointment panel's agreed records of sift and interview outcomes.

5.3 Appointment may be made subject to the provision of satisfactory references, if the appointments panel considers them to be necessary. No references will be taken up without the individual being informed in advance.

Raising concerns

GG/2018/147 Version 3

This policy sets out how to raise a concern at the GPhC

Policy details

Policy reference	GG/2018/147		
Version	3		
Policy author	Matthew Hayday, Head of Governance		
Approved for issue by	Council, 11 May 2017		
Effective from	06 April 2016	**Next review date**	31 March 2018 (or in line with changes in legislation or guidance)

Version control tracker

Version	Approved date	Description of change	Amendments by
2	06/12/2017	Names updated to reflect new structure	Helen Dalrymple, Council Secretary
3	XX/11/2018	1.3 strengthened and new 1.4 added to reference culture. Old references to PAW updated and link to PIDA protections included. Chair of EEAAG added as a contact.	Laura McClintock, Chief of Staff

Contents

1. Introduction and purpose

1.1. All of us at one time or another has a concern about what is happening at work. Usually these are easily resolved. However, when the concern feels serious because it is about a possible fraud, health and safety, or malpractice that might affect others or the organisation itself, it can be difficult to know what to do.

1.2. You may be worried about raising such a concern and may think it best to keep it to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or to the organisation. You may decide to say something but find that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

1.3. The Council and Chief Executive are committed to running the organisation in the best way possible and to do so we need your help. We have introduced this policy to reassure you that it is **safe, acceptable and encouraged** to speak up and to enable you to raise any concern you may have about malpractice at an early stage and in the right way. Rather than wait for proof, we would prefer you to raise the matter when it is still a concern.

1.4. At the GPhC we hold ourselves to the standards we expect of others. This means that we expect all staff to speak up when things go wrong or when they have concerns in the same way that we expect this from pharmacy professionals. Raising concerns at an early stage can help to identity areas that can be improved and it allows us to correct action as quickly as possible. This can also lead to wider opportunities for learning and improvement that can benefit everyone.

Remember: If in doubt - raise it!

2. Scope

2.1. This policy applies to all those who work for us; GPhC Council members, staff, associates and partners whether full-time or part-time, employed through an agency or as a volunteer. If you have a whistleblowing concern, please let us know.

2.2. If something is troubling you which you think we should know about or look into, please use this policy. If, however, you wish to make a complaint about your employment or how you have been treated, please use the grievance procedure which can be found in the staff handbook. This Whistleblowing Policy is primarily for concerns where the public interest is at risk, which includes a risk to the wider public, staff or the organisation itself.

3. Our assurances to you

3.1. Your safety

i. The Council and Chief Executive are committed to this policy. Provided you are raising a genuine concern, it does not matter if you are mistaken. Of course we do not extend this assurance to someone who maliciously raises a matter they know is untrue.

ii. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a genuine concern and we consider it a disciplinary matter to victimise anyone who has raised a genuine concern.

3.2. Your confidence

i. With these assurances, we hope you will raise your concern openly. However, we recognise that there may be circumstances when you would prefer to speak to someone confidentially first. If this is the case, please say so at the outset. If you ask us not to disclose your identity, we will not do so without your consent unless required by law. You should understand that there may be times when we are unable to resolve a concern without revealing your identity, for example where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

ii. Please remember that if you do not tell us who you are (and therefore you are raising a concern anonymously) it will be much more difficult for us to look into the matter. We will not be able to protect your position or to give you feedback. Accordingly you should not assume we can provide the assurances we offer in the same way if you report a concern anonymously.

4. How to raise a concern internally

4.1. Please remember that you do not need to have firm evidence of malpractice before raising a concern. However we do ask that you explain as fully as you can the information or circumstances that gave rise to your concern.

4.2. **Step one:** If you have a concern about malpractice, we hope you will feel able to raise it first with the person who carries out your performance review. This may be done verbally or in writing.

4.3. **Step two:** If you feel unable to raise this matter with your manager, for whatever reason, please raise the matter with:

Director of Fitness to Practice	Matthew Hayday	**matthew.hayday@pharmacyregulation.org**
Director of Insight, Intelligence and Inspection	Claire Bryce-Smith	**claire.bryce-smith@pharmacyregulation.org**

4.4. These people have been given special responsibility and training in dealing with whistleblowing concerns.

4.5. If you want to raise the matter confidentially, please say so at the outset so that appropriate arrangements can be made.

4.6. **Step three:** If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact (this may be the point at which Council members raise a concern given their position within the organisation):

Chief Executive & Registrar	Duncan Rudkin	**Duncan.rudkin@pharmacyregulation.org**
Chair of the Council	Nigel Clarke	**Nigel.clarke@pharmacyregulation.org**
Chair of the Audit & Risk Committee	Digby Emson	[insert after Council meeting]
Chair of the Remuneration Committee	Berwyn Owen	[insert after Council meeting]
Chair of the Efficiency and Effectiveness Assurance and Advisory Group	Mark Hammond	[insert after Council meeting]

4.7. The chairs of audit and riskand remuneration committees, and the chair of the Efficiency and Effectiveness Assurance and Advisory Group are members of Council. They and the other committee members have responsibility for reviewing some areas of the work within the GPhC and reporting back to the Council. As a result, the chairs have a broad understanding of the

organisation and have the independence to act on concerns they receive in the same way the Chief Executive and Registrar or Chair of Council would.

5. How we will handle the matter

5.1. We will acknowledge receipt of your concern within two working days. We will assess it and consider what action may be appropriate. This may involve an informal review, an internal inquiry or a more formal investigation. We will tell you who will be handling the matter, how you can contact them, and what further assistance we may need from you. If you ask, we will write to you summarising your concern and setting out how we propose to handle it and provide a timetable for feedback. If we have misunderstood the concern or there is any information missing please let us know.

5.2. When you raise the concern it will be helpful to know how you think the matter might best be resolved. If you have any personal interest in the matter, we do ask that you tell us at the outset. If we think your concern falls more properly within our grievance, bullying and harassment or other relevant procedure, we will let you know.

5.3. Whenever possible, we will give you feedback on the outcome of any investigation. Please note, however, that we may not be able to tell you about the precise actions we take where this would infringe a duty of confidence we owe to another person.

5.4. While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly and properly. By using this policy you will help us to achieve this.

5.5. If at any stage you experience reprisal, harassment or victimisation for raising a genuine concern please contact:

Head of Human Resources	Gary Sharp	**gary.sharp@pharmacyregulation.org**

6. Independent advice

6.1. If you are unsure whether to use this policy or you want confidential advice at any stage, there are a number of external sources of advice and support.

6.2. You may contact the independent charity **Protect** (formerly Public Concern at Work) on **020 3117 2520** or through their contact form **here**.

6.3. Their expert staff can talk you through your options and help you raise a concern about malpractice at work.

6.4. These organisations can also help you to understand the general law in this area. The Public Interest Disclosure Act 1998 (PIDA) protects workers in certain circumstances who are raising a concern to their employer or a relevant organisation about wrongdoing. Qualifying disclosures are disclosures where the worker reasonably believes that one or more of the following matters is either happening, has taken place or is likely to happen in the future:

i. A criminal offence
ii. The breach of a legal obligation
iii. A miscarriage of justice
iv. A danger to the health and safety of an individual
v. Damage to the environment
vi. A deliberate attempt to conceal any of the above

6.5. These external sources of advice and support will be able to help if you have specific questions about this area and they produce a range of guidance notes and other resources on their websites.

7. External contacts

7.1. Staff, Council members and associates are encouraged to raise, and attempt to resolve concerns internally. It is nevertheless recognised that there could be circumstances in which it was appropriate to raise a concern externally. In fact, we would rather you raised a matter with the appropriate regulator – such as the Professional Standards Authority, Health and Safety Executive, the National Audit Office or your MP- than not at all. The Professional Standards Authority is responsible for overseeing the UK's nine health and care professional regulatory bodies including the GPhC. They do not have any legal powers which would allow them to investigate complaints but they do have a policy on how they would respond to a whistleblowing concern raised with them. This can be found on their website http://www.professionalstandards.org.uk

7.2. Protect (formerly Public Concern at Work) will be able to advise you on using an external contact if you wish.

8. Monitoring/oversight

8.1. The Council is responsible for this policy and will review it every two years, or in line with relevant changes to legislation or guidance. Audit and Risk Committee will review the effectiveness of the policy. From time to time, Protect (formerly Public Concern at Work) will be asked to ensure that the policy remains in line with best practice. The Governance Team will monitor the daily

operation of the policy and if you have any comments or questions, please do not hesitate to let one of their team know.

Annex 1: How to raise concerns

The raising concerns & whistleblowing process

a) The raising concerns and whistleblowing process has been introduced to reassure you that is it safe, acceptable and encouraged to speak up and enable you to raise any concern you may have about malpractice throughout the organisation.

b) We want to process your concerns correctly. If the concern is a complaint you have about your employment or how you have been treated at work then we would ask you to follow the grievance procedure located in the staff handbook or contact H.R. This policy is primarily for concerns which include a risk to the wider public, staff or the organisation itself.

Our assurance to you

c) The Council and Chief Executive are committed to this policy. Provided you are raising a genuine concern, it does not matter if you are mistaken. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal. We will not tolerate and will discipline anyone who attempts to harass or victimise anyone raising a genuine concern.

d) If you want to raise the matter confidentially, please say so at the outset so that appropriate arrangements can be made.

e) We will acknowledge receipt of your concern within two working days.

f) We will assess it and consider what action may be appropriate. This may involve a formal review, an internal inquiry or a more formal investigation. We will tell you who will be handling the matter, how you can contact them and what further assistance we may need from you. If requested, we will write to you summarising your concern and setting out how we propose to handle it and provide a timetable for feedback. If we have misunderstood your concern or there is any information missing please let us know during this time.

The raising concerns & whistleblowing process

Step one

Verbally or in writing raise the concern with your immediate line manager or the person who conducts your performance review

Step two

If you feel unable to raise the matter with your manager, for whatever reason, please raise the matter with either of the following staff:

Matthew Hayday: **matthew.hayday@pharmacyregulation.org**

Claire Bryce-Smith: **claire.bryce-smith@pharmacyregulation.org**

These people have been given special responsibility and training in dealing with whistleblowing concerns

Step three

If these channels have been followed and you still have concerns, or if you feel the matter is so serious that you cannot discuss it with any of the above, please contact: (this may be the point Council Members raise a concern given their position within the organisation)

Chief Executive & Registrar	**Duncan Rudkin**	**duncan.rudkin@pharmacyregulation.org**
Chair of the Council	**Nigel Clarke**	**nigel.clarke@pharmacyregulation.org**
Chair of the Audit & Risk Committee	**Digby Emson**	**[to be added]**
Chair of the Remuneration Committee	**Berwyn Owen**	**[to be added]**
Chair of EEAAG	**Mark Hammond**	**[to be added]**

Independent advice and external contacts

If you are unsure whether to use this policy or you want confidential advice at any time you may contact the independent the independent charity Protect (formerly Public Concern at Work) on 020 3117 2520 or through their contact form **here**.

Anti-Bribery Policy

Effective from November XXXX

1. Anti-Bribery Statement

1.1 As an independent regulator, it is our role to protect, promote and maintain the health, safety and wellbeing of patients and of those who use pharmaceutical services. The GPhC is committed to carrying out its regulatory functions and statutory requirements in an honest and ethical way. As such, taking steps to avoid bribery and corruption is essential to conducting our duties.

1.2 The GPhC does not tolerate any form of bribery.

2. Procedure statement

2.1 The Bribery Act 2010 came into force on 1 July 2011. The offences under the Act can be summarised as:

1) bribing another person;
2) receiving a bribe;
3) bribing a foreign public official; and
4) failing to prevent bribery.

2.2 Directors and senior officers may be guilty of offences if they are implicated either actively or passively. For avoidance of doubt, the definitions relating to bribery are as follows:

- **Bribery:** 'Giving or receiving something of value to influence a transaction'[1]. Examples include gifting those in a position to influence decisions through monies, 'free' entertainment, 'free' holidays, or 'free' services.

- **Fraud:** The Chartered Institute of Public Finance and Accountancy (CIPFA) defines Fraud as the 'intentional distortion of financial statements or other records by persons internal or external to the organisation, which is carried out to conceal the misappropriation of assets or otherwise for gain.'

- **Corruption:** CIPFA defines corruption as: "The offering, giving or soliciting or acceptance of an inducement or reward, which may influence a person to act against the interests of the

[1] **www.sfo.gov.uk**

organisation." Examples of areas where corruption can occur include failing to follow procurement processes and making appointments outside of due process.

3. GPhC Commitment

3.1 Anti-bribery procedures are committed to from the top level of the organisation; Council and committee members, the Chief Executive & Registrar and Senior Leadership Group members complete a register of interests and a register of gifts and hospitality worth over £20 which are published and updated regularly.

3.2 Our Council applies the 7 Principles of Public Life (Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership) to all its work and decision making.

3.3 All GPhC Council members, committee members, associates and partners are required to uphold values based upon the *7 principles of public life* and comply with a code of conduct and behavioural standards. Similar arrangements are in place for employees.

4. Gifts, Hospitality, Entertainment and Expenses

4.1 All those associated with the GPhC must not engage in any activity that might lead to, or suggest a conflict of interest with our regulatory.

4.2 The offering, or giving, of gifts, hospitality and entertainment must:

- not be given or received with the intention of influencing a third party to obtain or retain business or business advantage, to reward the provision or retention of business or business advantage, or in an explicit or implicit exchange for favours or benefits;
- not constitute an offence under the Bribery Act 2010;
- be given at a corporate level, not an individual level;
- not include cash or a cash equivalent;
- be appropriate, reasonable, proportionate, given in good faith and at an appropriate time; and
- be given openly.

5. Your Responsibilities

5.1 You must ensure that you have read and understood this policy. You must comply with it and its terms when acting on behalf of the GPhC. You must inform the GPhC of the details of any third

party engaged by you, in line with the authority framework and procurement policy, on behalf of the GPhC and you must ensure that they agree to be bound by, and comply with, the terms of this policy.

6. Record Keeping Provisions – Purchases

6.1 You must ensure that you retain purchase documentation identifying and relating to any third party or other person engaged by you on behalf of the GPhC.

7. Risk Management and Due Diligence

7.1 As part of its regular risk management processes, the organisation assesses the nature and extent of its exposure to risks of bribery, and the measures taken to mitigate those risks. The strategic risk register is updated every quarter by the Senior Leadership Group and is reviewed at every meeting of the Audit & Risk Committee and subsequent meeting of Council.

7.2 The assessment of bribery risk will, in part, be informed by due diligence exercised through GPhC Human Resources, whistleblowing and financial and procurement policies and procedures.

8. Penalties

8.1 Violations of the UK Bribery Act 2010 are a serious matter and could result in significant criminal and/or civil penalties. Penalties include imprisonment for up to 10 years for individuals committing the offence, together with unlimited fines.

8.2 Fines imposed on individuals will not be paid by the GPhC. A violation will also result in disciplinary action by the GPhC up to, and including, termination of employment or other contract.

8.3 While the GPhC is not a commercial organisation, third parties with which it associates must be mindful of their responsibility to prevent bribery on their behalf. Penalties for corporate offences include unlimited fines for the business. Senior Officers who were aware of the bribes may also face penalties.

9. Communication

9.1 The anti-bribery policy will be shared with all staff via the policy and procedure library on the intranet. It will also be published on the GPhC's website as part of the organisation's governance and assurance framework. The register of interests is published via the GPhC website as well as the register of gifts and hospitality for Council members, external committee members and members of the Senior Leadership Group.

9.2 This policy will be communicated to our suppliers, contractors, and business partners who will be asked to review it and abide by its terms.

10. Guidance and Raising Concerns

10.1 If an instance of bribery is suspected or detected internally, it should be raised through the usual line management chain. Where the circumstances mean this is not possible or appropriate the raising concerns policy should be used, which explains that serious concerns can be raised with Chief Executive and Registrar, or other named senior individual, directly so that the matter can be resolved efficiently and effectively.

10.2 Suppliers, contractors and other third parties can make contact confidentially with the GPhC by emailing GovernanceTeam@pharmacyregulation.org or by writing to:

Head of Governance
General Pharmaceutical Council
25 Canada Square
Canary Wharf
London E14 5L

10.3 Anyone raising a concern in good faith will not be criticised or penalised in any way, even if it is shown, after investigation, that they were mistaken. Any reprisal or victimisation against anyone who has raised a genuinely-held concern will not be tolerated, and itself will be treated as a disciplinary matter.

11. Supporting policies

11.1 This policy is supported by a range of other supporting policies and procedures, which can be found on the Governance, HR and Finance pages of the intranet, and in the policies and procedures library. This includes:

- Gifts and hospitality policy
- Declarations of interest policy
- Staff and non-staff expenses policies
- Staff Code of Conduct
- Values, conduct and behaviours for Council members, associates and partners
- Disciplinary policy and procedure
- Raising concerns and whistle-blowing
- Standing financial instructions

- Procurement Policy
- Scheme of Delegation and Authority Framework

Policy author:	Laura McClintock
Job title:	Chief of Staff
Policy reference:	GG/2017/156
Effective from:	XX November 2018
Review date:	XX November 2021
Agreed by:	Council on XX November 2018

Non-Staff Expenses Policy

Effective from November 2018

1. Introduction and purpose

1.1 As an equal opportunities organisation, the GPhC maintains an expenses policy to ensure that individuals are not either financially disadvantaged or advantaged because of genuine business expenses.

1.2 Any expenses policy should be easily understood and should not be open to a wide range of interpretation. Expenses should be directly and solely related to GPhC business. It is important to set clear guidelines. Nonetheless, anyone claiming expenses should be encouraged to seek advice from the GPhC's finance or governance team on the hopefully rare occasions when they have an expense that does not appear to be covered by the policy, so as to facilitate a reasonable and pragmatic approach.

1.3 If at all possible, advice should be sought before the expense is incurred. It is nevertheless recognised that there may occasionally be circumstances where someone claiming expenses will need to make a reasonable judgement about what is appropriate, for example, when a genuine emergency occurs and tickets need to be booked or arrangements altered at the last minute.

1.4 The expenses policy should be equitable and inclusive, signalling that the GPhC values diversity and is keen to recruit people from a broad range of backgrounds. Provisions for parents, carers or people with disabilities are referred to below.

1.5 *Childcare or carer's costs*

It is important that the GPhC is able to understand and engage with the broad range of its stakeholders, including parents and carers. The GPhC should therefore aim to assist and encourage parents and carers to join the GPhC. Where appropriate, the GPhC will meet reasonable childcare and carer's expenses on production of a receipt. Either the Head of Governance or Head of Finance (depending on availability) will determine the appropriateness and reasonableness of claims on a case by case basis.

1.6 *People with disabilities*

Again, it is important that the GPhC values diversity and seeks to recruit people from a broad range of backgrounds. Expenses may therefore be adjusted to cover the requirements of people with disabilities, such as taxis instead of public transport where necessary. Any such adjustments would be subject to approval by the Head of Governance or the Head of Finance on a case by case basis.

1.7 Complying with the non-staff expenses policy will ensure that no tax liability is incurred by Council members in respect of expenses. Other claimants of expenses will need to ensure that they have arrangements in place to asses any tax liability that could result from expenses.

1.8 It should be noted that the final decision on whether to reimburse any expense rests with the GPhC. Submitting a claim or invoice does not mean that expenses will be reimbursed automatically.

2. Purpose of Policy

2.1 The policy is intended to provide clear information and guidance on expenses that may be claimed which are wholly, necessary, and exclusively incurred during your business on behalf of the GPhC.

3. Policy statement

3.1 The GPhC expenses policy for non-staff is set out at Appendix 1.

4. Application of policy

4.1 This expenses policy applies to Council members, associates, partners and other groups that incur expense in undertaking activity on behalf of the GPhC. Staff matters are dealt with separately in the Staff Expenses Policy.

5. Measurement and evaluation

5.1 This policy is reviewed by the Remuneration Committee and recommended to Council for adoption every two years unless there are any significant issues or concerns raised in the intervening year.

Policy author:	Matthew Hayday
Job title:	Head of Governance
Policy reference:	GPhCXXXXXX
Effective from:	01 June 2017
Review date:	01 June 2018
Agreed by:	Council June 2017 (Updated in November 2018)

Appendix 1

Non-Staff Expenses Policy

1. General

1.1. This policy applies to all who are eligible to claim expenses for undertaking business on behalf of the GPhC, but who are not members of GPhC staff. Business means a meeting or activity being undertaken on behalf of the GPhC.

1.2. You should make travel and accommodation bookings at the earliest reasonable opportunity in order to obtain the best rates. Charges for late alterations or cancellations should be avoided as far as possible.

1.3. Expense claims should be supported by receipts in all cases other than for bus and tube travel or parking meters. Receipts must be itemised. Summary credit card receipts will not be accepted.

1.4. The GPhC will accept electronic claims and invoices for expenses accompanied by scanned or photographed receipts and email confirmations for travel and hotel bookings to improve efficiency in processing expenses. You must keep a copy of original receipts for a year in case they are required for audit purposes.

1.5. You must not attempt to alter or amend receipts. If there is a part claim on a receipt this should be made clear with an explanatory note. Claims with amended or altered receipts will not be reimbursed.

1.6. The GPhC does not reimburse expenses for postage of expense claims or invoices nor provide pre-paid envelopes.

1.7. You should use the most cost-effective means of travel. In London, this means bus and tube using a cost-effective means of payment such as an Oyster card or contactless payment method.

1.8. No out-of-pocket expenses other than those detailed below will normally be payable.

1.9. All associates and partners must invoice for expenses. Council members, witnesses and volunteers should make expenses claims using the expense form. Council members' expenses will be reimbursed via payroll. Other individuals eligible to claim expenses for GPhC business should seek advice from their staff point of contact on whether to use an expenses claim form or invoice.

1.10. You are expected to act honourably and sensibly within the spirit of this policy. Any questions about whether a particular expense is payable should be raised with the Head of Governance or Head of Finance.

1.11. All claims or invoices must be submitted within three months of the expenditure being incurred or the claim may be forfeited. Claims or invoices will be reimbursed in line with the GPhC's standard 30 day term.

2. Travel – general

2.1. Individuals should use the most cost-effective means of ticket purchase for travel. Tickets should be booked as far in advance as possible.

2.2. Reimbursement for travel expenses will be based on journeys from your home address to the place at which you are undertaking business for the GPhC or the actual journey, **whichever is the shorter**. If the cost of the journey is greater than that from your home address then the GPhC will only reimburse the equivalent cost of the journey from your home on the same day. Evidence of both costs (such as a screen shot from the booking page) must be provided with the claim.

3. Train and air travel

3.1. If you travel by air and rail while on GPhC business, you must travel standard or economy class.

3.2. Where the total time spent on a train or plane on a single leg of a journey (meaning one flight or one train journey, not the total time travelling) is in excess of 5 hours, an upgrade to the next class of travel will be allowed, but you must ask for the agreement of the Chief Executive and Registrar before booking.

3.3. When travelling by rail you must purchase the lowest price ticket option available, and where possible, book tickets in advance. You may only book an open ticket if you do not know when your business will end and you have sought advanced authorisation from your staff point of contact.

3.4. Rail cards (16-25, Senior, or any other type) will be reimbursed if you can demonstrate that the savings to the GPhC are greater than the cost of the rail card over the lifetime of the rail card. You will need to get prior authorisation. Rail cards will not be reimbursed where they are not cost effective, for example, for a single journey, and have not been authorised in advance.

4. Tube and Bus

4.1. It is not always practical to obtain a receipt for tube or bus travel, particularly when using a cost-effective means of payment such as an Oyster card or contactless payment method. Tube and bus fares may therefore be claimed without a receipt.

5. Taxis

5.1. The use of taxis is not an entitlement and you must seek prior authorisation before using taxis. Taxis are only to be used in exceptional circumstances and you must submit an explanatory note with the receipt when making a claim or submitting an invoice. Claims without prior authorisation and reasonable explanation will not be accepted.

6. Car

6.1. Mileage may be claimed in line with HM Revenue & Customs rates, where the use of a car is the most cost-effective means of travel. Costs of car parking may be claimed on the basis of receipts. Costs of parking meters may be claimed without a receipt. Mileage claims will not be accepted for travel in London as public transport offers much more effective options.

6.2. No payment will be made for congestion charges, charges for fixed penalty notices or charges where a vehicle has been clamped or towed away.

6.3. It is your responsibility to ensure that you have appropriate car insurance in place for business travel.

7. Overseas travel

7.1. No overseas travel may be claimed unless prior approval has been given by the Head of Governance or Head of Finance.

8. Accommodation and breakfast

8.1. The costs of accommodation and breakfast may be claimed when it is impractical to travel home after a meeting, or to travel from home to a morning meeting. This means where journeys are longer than 3 hours and require individuals to leave home before 6.00am for a meeting or depart after 7.30pm from a meeting to return home. The calculation must be based either on your home address or actual journey, whichever is the shorter.

8.2. The GPhC will negotiate rates for hotels that are convenient to the location of its meetings. Overnight accommodation for business in London must be booked by GPhC staff.

8.3. If you have a membership or scheme that is more cost effective for staying in London than the GPhC hotel booking, you may claim for this if this has been authorised in advance.

8.4. The maximum cost that will be reimbursed for hotel accommodation and breakfast is an average of £150 including VAT per night over the total number of nights in London and £130 per night including VAT outside of London. It may occasionally be necessary to exceed the maximum negotiated rates for accommodation, for example, if a late booking is necessary, but you must get approval from your staff contact point first.

8.5. Claims above the maximum rate will not be reimbursed unless authorised in advance. Costs other than accommodation, such as newspapers and the use of a minibar are the responsibility of the individual and will not be reimbursed by the GPhC.

8.6. Room service charges (the additional charge for having food delivered to your room) will not be reimbursed.

9. Subsistence

9.1. The cost of lunch or dinner, when required, may be claimed up to the following limits. The cost of alcoholic drinks will not be reimbursed:

- Breakfast: £6. This expense is available when no overnight stay is involved; provided the start time for the business means that the individual would have to leave home before 6.00am. Where accommodation is booked for an overnight stay breakfast should be included in the hotel rate. Separate claims for breakfast will not be accepted.
- Lunch: £8 maximum. This expense is available where the period of absence is for more than 8 hours with no official lunch provided.
- Dinner: £30 maximum in London, £25 maximum outside London. This expense is available where the period of absence is for more than 12 hours with no official food provided.

9.2. The period of absence should be calculated on the actual time of absence based on the departure time from your home and the time of arrival back at home. The calculation must be based either on your home address or actual journey, **whichever is the shorter**.

9.3. The cost of travel to and from restaurants will not be reimbursed in any circumstances.

9.4. Room service charges (the additional charge for having food delivered to your room) will not be reimbursed.

9.5. In line with HMRC guidance, service charges included within the total allowance can be claimed as part of a complete subsistence claim. If you leave a tip, cash or otherwise, this cannot be claimed.

10. Childcare or carer's costs

10.1. The reasonableness of any claims for childcare or carer's expenses must be determined on a case by case basis by the Head of Governance or Head of Finance. Subject to this, reasonable childcare and carer's expenses will be met, on production of a receipt.

11. People with disabilities

11.1. Expenses may be adjusted to cover the requirements of people with disabilities, for example, taxis instead of public transport where necessary.

12. Witness expenses

Loss of earnings

12.1. Many employers will allow employees time off to attend hearings without loss of earnings. If your employer will not permit this, the GPhC will reimburse net loss of earnings, depending on the period of absence, with documentary evidence (for example, payslip or letter from your employer). The following maximum limits apply to ordinary (factual) witnesses:

- £33.50 for a period of 4 hours or less,
- £67 per day for a period exceeding 4 hours

12.2. The maximum limits are higher for "professional" witnesses, whose evidence relates to matters arising out of their profession and who belong to one of the following professions: pharmacist, doctor, dentist, veterinary surgeon, solicitor, barrister or accountant. If you believe that you are a professional witness, you should obtain advance authorisation from the Fitness to Practise team. Reimbursement will be subject to documentary evidence as above and the following upper limits:

- £83.50 for a period of 2 hours or less
- £117 for a period of 2-4 hours
- £174 for a period of 4-6 hours
- £234 per day for a period in excess of 6 hours

Reimbursement of locum fees (witnesses only)

12.3. If you are a pharmacist, doctor or other healthcare professional, your employer (or yourself, if you are the proprietor of the business) can claim for the cost of employing a locum to cover the period of your absence.

12.4. You will need to obtain advance authorisation from the Fitness to Practise team, the claim must be supported by a receipted invoice for the locum fees and reimbursement will be subject to an overall ceiling of £160. If you (rather than your employer) make the claim, you must confirm whether the locum is a person connected to you, e.g. family member or colleague, etc.

Claims in respect of non-witnesses

12.5. The GPhC will not normally reimburse the cost of a non-witness accompanying you to the hearing. Exceptions can however be made, with advance authorisation, for example, in respect of someone accompanying a child witness or an older witness or disabled witness, or where the witness has to bring a young child and needs someone to help care for that child.

Expert witnesses

12.6. An expert witness is someone who has been asked to give evidence, usually opinion evidence, because of expertise in a particular field.

12.7. The GPhC will agree fees, in advance, for preparing a report and attending a hearing, and the GPhC will reimburse travel and accommodation expenses in line with this policy.

Meeting paper

Council on Thursday, 08 November 2018

Public business

Reporting on the September 2018 Registration Assessment

Purpose

To update Council on candidate performance in the September 2018 Registration Assessment.

Recommendations

Council is asked to note:

i. candidate performance data (Appendix 1) and our response to feedback on the September 2018 Registration Assessment from the British Pharmaceutical Students' Association (BPSA); and

ii. the Board of Assessor's report to Council (Appendix 2) and the assurance it provides about the September 2018 sitting.

1. Introduction

1.1 Passing the GPhC's Registration Assessment is a pre-requisite for applying to register as a pharmacist. There are two sittings every year, in June and September. This paper discusses the September 2018 sitting.

1.2 Responsibility for the Registration Assessment is split between the GPhC and the Board of Assessors (the 'Board'). The Board sets and moderates the Assessment and agrees reasonable adjustments for candidates with specific needs; the GPhC is responsible for operational matters, including registration, venues and invigilation.

1.3 After each sitting the Board produces a report on matters relevant to its work and the GPhC produces one relevant to its work (this paper). Both reports respond in part to a third, based on feedback provided by candidates to the BPSA. The Board and GPhC have responded to recommendations in the BPSA's report separately, depending on the focus of the recommendations.

1.4 This sitting did not raise any new issues.

2. Feedback on the sitting

2.1 Each year the BPSA collects feedback from candidates who sat the Registration Assessment. The feedback is collated in to a report which we and the Board of Assessors consider. In its report on the September 2018, the BPSA made 4 recommendations, three of which have been addressed by the Board of Assessors in their report. The fourth is:

Recommendation 1: The GPhC should work to improve signage to ensure clear directions are provided at the assessment centres, particularly large centres, to help candidates find the exam hall.

We encourage candidates to arrive at (large) centres in plenty of time to locate assessment halls, which can be a 10-15 minute walk from main entrances. The halls are signposted but there may be signposts to many other events running at the same time as well – candidates should be prepared for this and we will highlight it in our guidance to candidates next year.

2.2 In addition to the BPSA's report we received feedback from individual candidates. Points raised included:

- *Some question take longer to answer than others*: In a given paper, there are some simple questions and some more complex ones. The complex ones can take longer than the average to answer but this is taken in to account by the Board when setting a paper.
- *The perceived ambiguity of questions*: In general, candidates prefer questions with clear and unambiguous answers, that is true-false questions. However, our single best answer questions are designed to test judgement, so as well as including the 'best' answer they include a number of others which are plausible.
- *Finding information in SPCs (summary of product characteristics leaflets)*: SPCs are provided to candidates as one of the resources they need to refer to in order to answer particular questions. While they can be lengthy, they are also standardised and we would expect candidates to be familiar with these from their experience in pre-registration training.

3. Equality and diversity implications

3.1 As is the case for every sitting of the Registration Assessment, we considered a range of adjustment requests for the September 2018 sitting. The data are as follows:

- 126 adjustment requests granted;
- 15 requests granted partially. When a request is granted partially it is because the request and supporting evidence does not justify granting the request in full; and
- 10 requests not granted. Requests are not granted when the request and supporting evidence does not justify granting the request.

3.2 The most common reasons for adjustment requests were specific learning needs (eg dyslexia, dyspraxia and dyscalculia), anxiety/stress/panic attacks and muscular/neural/joint ache or pain

3.3 The most common adjustments granted were extra time and specific seating requests (eg sitting near to a toilet).

3.4 All assessment centres can accommodate adjustment candidates.

4. Communications

4.1 This paper is a public document but it will be shared directly with relevant stakeholders.

5. Resource implications

5.1 There are no current resource implications for the GPhC.

6. Risk implications

6.1 There are no risks associated with this report.

7. Monitoring and review

7.1 The Registration Assessment is reviewed after every sitting by the GPhC and Board of Assessors. The Board reports on each sitting to Council and the chair attends Council once a year to discuss the year's sittings.

Recommendations

Council is asked to note:

i. candidate performance data (Appendix 1) and our response to feedback on the September 2018 Registration Assessment from the British Pharmaceutical Students' Association (BPSA); and
ii. the Board of Assessor's report to Council (Appendix 2) and the assurance it provides about the September 2018 sitting.

Damian Day, Head of Education
General Pharmaceutical Council

damian.day@pharmacyregulation.org

20th October 2018

Appendix 1

September 2018 Registration Assessment performance breakdown by characteristic

Table 1a: *Overall performance*

			Part 1		Part 2	
Number of candidates	**Number of passing candidates**	**% pass rate****	**Total number of marks available***	**Average % mark**	**Total number of marks available***	**Average % mark**
834	544	65.23	39	79.04	118	69.90

*In a sitting, there are 40 questions in Part 1 and 120 questions in Part 2. At the post-assessment stage, the Board of Assessors may remove a question or accept more than one answer for a question, if there is evidence to support doing so. In this sitting, the Board of Assessors removed one question from Part 1 and removed two questions from Part 2. This adjusted the number of marks available to 39 in Part 1 and 118 in Part 2.
** Percentages have been rounded to two decimal places.

Table 1b: *Paper pass marks*

Paper	**Number of questions required to pass each part**
Part 1	25 (out of 39)
Part 2	79 (out of 118)
To pass the Registration Assessment, both parts must be passed. The number of questions required to pass each part may vary from paper to paper and year to year depending on the difficulty of questions and papers. Note that the number of questions required to pass is the standard and the pass rate is the percentage of candidates who met the standard.	

Table 2: *Performance by sitting attempt*

Sitting attempt	Number of candidates	Number of passing candidates	% pass rate
1st	319	196	61.64
2nd	448	317	70.60
3rd	67	31	46.27

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

Table 3: 1st attempt by education route

			Average % mark	
Education route	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
OSPAP	30	83.33	80.34	73.28
MPharm	288	59.38	78.21	68.91

Table 4: 1st attempt by sex

			Average % mark	
Sex	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
Male	142	61.27	80.30	69.21
Female	176	61.93	76.88	69.41

Table 5: 1st attempt by age range

			Average % mark	
Age Range	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
36 and over	34	47.06	69.61	65.23
26 - 35	72	54.17	75.25	67.80
25 and under	212	66.51	80.89	70.49

Table 6: 1st attempt by country of training

			Average % mark	
Country* **	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
Scotland	17	76.47	80.54	72.73
England	295	60.34	78.24	69.04

*** Data for Welsh candidates are too low to report (<10).

Table 7: 1st attempt by sector

			Average % mark	
Sector** *****	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
Hospital	23	86.96	86.85	76.79
Community	294	59.52	77.69	68.71

****A candidate's sector refers to the placement of the longest duration. If placements of equal duration were undertaken the sector of the most recent placement has been used.
***** Data for candidates from industry are too low to report (<10).

Table 8: 1st attempt by ethnicity (≥ 20 candidates in a category)

			Average % mark	
Ethnicity	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
Asian - Other	29	55.17	74.80	66.72
Black - African	36	52.78	67.24	65.4.
Chinese/ Chinese British	36	63.89	84.12	70.53
Indian	41	56.10	79.99	67.98
Pakistani	56	62.50	79.17	69.42
White - British	33	72.73	83.61	72.91

Data for candidates from other categories are too low to report (<20).

Table 9: 1st attempt by school of pharmacy attended (MPharm degree)

			Average % mark	
School of Pharmacy******	**Number of candidates**	**% pass rate**	**Part 1**	**Part 2**
University of Bath	11	63.64	82.52	69.95
University of Bradford (4-year continuous degree)	10	60.00	73.59	68.56
University of Bradford (5-year sandwich degree)	10	50.00	82.56	67.03
University of Brighton	25	40.00	69.74	64.03
De Montfort University	12	66.67	80.56	70.48
University of East Anglia	14	64.29	82.97	72.09
Keele University	17	52.94	80.09	66.30
Liverpool John Moores University	18	50.00	75.36	65.73
Medway School of Pharmacy (universities of Greenwich and Kent)	17	76.47	80.39	71.19
University of Portsmouth	11	27.27	76.69	64.41
University of Reading	14	50.00	78.94	64.71
University of Strathclyde	22	63.64	80.77	70.49
University of Sunderland	18	72.22	81.62	72.88
University College London	19	78.95	83.81	74.35
OSPAP Aston	10	90.00	77.95	74.83

******Data from other schools are too low to report (<10)

Appendix 2

Report to the Council of the General Pharmaceutical Council on the September 2018 Registration Assessment

1. Introduction

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

- a four-year MPharm degree accredited by the GPhC[1]; then
- 52 weeks of pharmacist pre-registration training; and
- the GPhC's Registration Assessment.

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

1.3 The Registration Assessment is an examination with two papers: part 1 (morning) and part 2 (afternoon). It is set and moderated by the Board of Assessors, the authors of this report.

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

1.5 *Part 2*: The part 2 paper is two and a half hours long (150 minutes) and comprises 120 questions: 90 are single best answer questions (SBAs) and 30 are extended matching questions (EMQs). Calculators are not permitted in Part 2.

[1] Non-EEA pharmacists wanting to register in GB take a one-year university Overseas Pharmacists' Assessment Programme (OSPAP) instead of an MPharm degree then enter pre-registration training and sit the Registration Assessment.

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

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

1.8 Candidates with specific needs may sit the assessment in a separate adjustments room and all centres have adjustment rooms.

2. Reporting to Council

2.1 There are two sittings of the Registration Assessment every year, in June and September, and the Board of Assessors reports to the GPhC's Council after each one. This is the report for September 2018.

3. September 2018 summary statistics

1. Candidate numbers	Number	% of total[2]
Total number of candidates	834	100
Number of first sitting candidates	319	38.2
Number of second sitting candidates	448	53.7
Number of third sitting candidates	67	8.0

Note that it is always the case that while the majority of candidates sitting in June are first sitters[3], there is always a more equal balance between first sitters and resitters in September.

[2] Percentages have been rounded to one decimal place.
[3] The percentages for June 2018 are first sitters – 89.8%, second sitters – 4.9% and third sitters – 5.2%.

Candidate performance – pass rates	Number	%
Overall pass	544	65.2
Overall fail	290	34.8
First sitting candidates - pass	196	61.6
Second sitting candidates - pass	317	70.6
Third sitting candidates - pass	31	46.3

4. Paper and question analysis

Question performance

4.1 The questions performed as expected in both papers. One question was removed from Part 1 and two from Part 2. The Part 1 question was removed because the units for one value was incorrect. One question in Part 2 was removed because, on reflection, the Board decided that an early career pharmacist may not have known the answer. The Board decided to remove a second question in Part 2 because it was not worded as clearly as it could have been (but an early career pharmacist would have known the answer).

The balance of questions

4.2 The balance of questions was consistent with the requirements of the Registration Assessment Framework:

Total % of the paper questions high-weighted outcomes: 65.8
Total % of the paper questions medium-weighted outcomes: 26.4
Total % of the paper questions low-weighted outcomes: 7.8

5. Standard setting

5.1 *Setting the standard*: the standard of each question is set by a panel of standard setters who are all pharmacists with current experience of pre-registration trainees and early-career pharmacists. The standard of a paper is set based on the standard set for each question. Further information on creating papers and setting standards can be found at https://www.pharmacyregulation.org/education/pharmacist-pre-registration-training-scheme/key-dates-scheme/registration-assessment.

5.2 *Pass requirements*: In order to pass the Registration Assessment, both Part 1 and Part 2 must be passed. The number of questions required to pass each part in this sitting were:

Part 1: 25 questions (/39 questions)
Part 2: 79 questions (/118 questions)

6. Feedback to the BPSA

6.1 As in previous years, the Board would like to thank the BPSA for its report, which was considered at the Board's meeting on the 18th October 2018. The report was based on 48 responses, 5.9% of the candidates who sat the Registration Assessment in September 2018.

6.2 One of the recommendations made by the BPSA is operational and will be considered by the GPhC.

6.3 The other three recommendations, which are relevant to the work of the Board, are:

Recommendation 2: The BPSA believes that where a question with a mistake has been identified during the exam, the question should be announced as discounted from the paper, particularly when a mistake prevents candidates from answering the question properly or potentially causing confusing amongst candidates once an amendment has been announced.

Board's response: The Board cannot make a decision about removing a question until it has reviewed all the relevant evidence, which cannot be done until after a sitting. However, if a question is found to be unfit for purpose, it is always removed, as part of the Board's post-sitting protocols. We have asked the GPhC to make reference to this in the Pre-registration Manual.

Recommendation 3: The GPhC should provide a reasonable amount of extra time to candidates when a correction to a mistake on a question is announced during the exam. This should help to relieve any added stress and pressure on the candidates.

Board's response: Announcements are typically very short and so will have no impact on the time allocated for a paper, nor cause any added time pressure to candidates. Therefore, any time extension would be inappropriate. If a candidate feels that an announcement has had an undue effect on their ability to perform, they can request a nullification (and, should this be granted by the Board, be allowed a resit without prejudice).

Recommendation 4: The GPhC should ensure that the calculations within Paper 2 of the assessment use simpler numbers and are answerable within the average time limit for each question in this paper.

Board's response: Some questions take longer than others to answer and a Part 2 question involving a calculation might take longer than the average. For this reason, it would not be appropriate to cap the notional time length for such questions. Additionally, the Board reviews papers to ensure they are not unfairly long

Professor Andy Husband, Chair, on behalf of the
Board of Assessors

October 23rd 2018

Minutes of the **Remuneration Committee** meeting held on **Thursday 27 September 2018** at 25 Canada Square, London at 10:00am

TO BE CONFIRMED FEBRUARY 2019

Minutes of the public session

Present

Berwyn Owen (Chair)

Nigel Clarke

Elizabeth Mailey

Rob Goward

Janet Rubin

Apologies

Alan Kershaw

In attendance

Duncan Rudkin (Chief Executive & Registrar)

Laura McClintock (Chief of Staff)

Francesca Okosi (Director of People)

Gary Sharp (Head of Human Resources – Interim)

Elaine Mulingani (Associates and Partners Manager)

Helen Dalrymple (Council Secretary)

1. Attendance and introductory remarks

1.1. The Chair welcomed those present.

2. Declarations of interest

2.1. The Committee agreed that any declarations of interest should be made before each item.

3. Minutes of the last meeting

3.1. **The minutes of the public session held on the 18 April 2018 were confirmed as a fair and accurate record.**

4. Actions and matters arising

4.1. Action reference 24.3 from the meeting on the 29 September 2016, regarding data around executive pay benchmarking, would be covered in the reward and recognition item on that day's agenda.

5. Introduction to the review of reward and recognition

5.1. Francesca Okosi (FO) introduced David Conroy (DC), Principal Consultant at Beamans Management Consultants, who presented an introduction to the review of reward and recognition.

5.2. Duncan Rudkin (DR) declared an interest on behalf of all staff present. Nigel Clarke declared an interest on behalf of Council members present and Rob Goward declared an interest as he had worked with David Conroy in a previous role.

5.3. DC told the committee that from what he had seen so far, there was a lot of good practice at the GPhC and wholesale change would not necessarily be needed.

5.4. Members asked how expectations around the review were being managed. DC acknowledged the challenge to communications. Staff surveys had indicated a negative attitude to pay but the benefits offered by the organisation to staff should also be taken into consideration.

5.5. Gary Sharp (GS) told the committee that results from another Pulse survey were imminent. Staff were aware that the review was going to be carried out and a presentation would go to the Employee Forum in October.

5.6. DC assured the committee that the link between performance and pay would be thoroughly addressed by the review.

5.7. Members discussed placing a focus on developing managers' capability as well as defining good performance and how to measure it.

5.8. Links here could be drawn with the current work on the organisation's culture. The statement 'We all know what success looks like' fed straight into developing performance management which would be a main focus of the review.

5.9. The committee asked what implications the location of the office had on support staff. DC replied that the office itself was very positive in that the facilities were well maintained and good to work in. The limitations caused by most staff being unable to afford to live in the same area and the occasional unreliability of public transport should be acknowledged. Any organisation had to bear such factors in mind when deciding their location, especially in London.

5.10. One member asked DC what access Beamans Management Consultants had to benchmarking data. DC said that they had access to a full range of data, the skill often lay in knowing what was relevant and how to use the data intelligently.

5.11. The committee discussed executive pay, they asked how the review would engage with the Senior Leadership Group. DC agreed that this would be fundamental to the process and meetings had already been set up with them to obtain their input.

5.12. Members wanted to know how the pay award had been received by staff. FO reported that there had not been a significant increase in staff turnover but they had received robust feedback that pay should be linked to contribution.

5.13. The committee asked that the slides be sent round following the meeting. A further meeting would be held early in 2019 to enable the committee to have an update on the review.

ACTION: HD

6. Council member remuneration

6.1. Laura McClintock (LM) presented **18.09.Rem.01,** which reviewed remuneration rates for Council members.

6.2. The committee asked whether remuneration had any effect on the recruitment of new Council members. LM replied that recruitment had just started. An agency was assisting with the process and no concerns had been raised by them or by the appointments panel.

6.3. Should any information become available on any unintended consequences of remuneration rates then it would be welcome; there was a balance to be struck on appropriate remuneration for the role of Council member and the amount being intimidating to good candidates on lower salaries.

6.4. It was agreed that the chair of the Efficiency and Effectiveness Assurance and Advisory Group (EEAAG) should be added to the recommendations part of the paper.

6.5. Members discussed having a more comprehensive 'deep dive' into Council member remuneration every two years and agreed that this would be a good idea.

6.6. **The committee agreed to advise Council that there was no case this year for a substantive review of the remuneration for Council members, the Chair of Council and the discretionary**

payments for Chairs of the Audit and Risk and Remuneration Committees and the Efficiency and Effectiveness Assurance and Advisory Group and that these should remain unchanged.

7. Review of associate remuneration

7.1. Elaine Mulingani (EM) presented **18.09.Rem.02,** which reviewed the remuneration of the GPhC's associates.

7.2. The chair of the committee took the opportunity to thank Elaine for her work. This was her last Remuneration Committee meeting as she would be leaving the organisation in November.

7.3. The chair drew members' attention to para. 8.10 of the paper which said that the Senior Leadership Group (SLG) were not minded to recommend any increase on any member fee to the committee.

7.4. Members asked EM about how she thought that associates currently felt about their remuneration. She replied that there were no current issues and that there had not been any problems in recruiting over recent months.

7.5. The committee discussed the training fee and agreed that while it looked reasonable at the moment, it was right to keep it under regular review.

7.6. **The committee agreed not to amend any of the current remuneration rates for the GPhC's associates.**

8. Statutory committees' cancellation policy

8.1. EM presented **18.09.Rem.03**. This paper reviewed the cancellation policy for statutory committee meetings and hearings.

8.2. The paper proposed some changes that would simplify the scale by which claims could be made for cancelled or adjourned hearings and meetings, bringing the terms more in line with other regulators.

8.3. The committee thanked EM for the paper which they said clarified a complex situation. They asked how the proposals would land with those that they affected. EM said that in discussions so far there had been no push back. The recent recruitment of new statutory committee members had been done on the understanding that the cancellation policy may change and no one had expressed concern.

8.4. A member asked whether progress was being made in improving the overall process of scheduling and cancelling hearings and meetings. EM told the committee that all cancellations and adjournments were reviewed to understand why they had occurred.

8.5. FO said that teams in Fitness to Practise and Hearings were working together to understand how the time taken for hearings and meeting was estimated and how to improve accuracy on this.

8.6. **The committee agreed the recommendations at 3.4. of the paper for changes to the wording of the cancellation policy for statutory committee meetings and hearings.**

9. Expenses policies

9.1. LM presented **18.09.Rem.04**, which proposed amendments to the staff and non-staff expenses policies.

9.2. Concerning the non-staff expenses policy, the committee asked what impact removing the right to claim for another train ticket if a meeting had finished early would have. LM said that the data itself was not available but that the Hearings team had reported that it would not be significant.

9.3. **The committee:**

i. **agreed the proposed amendments to the expenses policy for non-staff and associates**

ii. **recommended the staff expenses policy to the Chief Executive and Registrar for approval**

10. Health and wellbeing

10.1. FO presented **18.09.Rem.05**, which provided the committee with an update on the activities carried out to improve employee health and the wellbeing of the workforce.

10.2. The paper covered annual events, staff networks and programmes developing awareness of mental health. These themes would be pulled together to form a strategy and would be added to the work being carried out in the reward and recognition review to highlight to staff what was available to them.

10.3. Figures on staff engagement with the activities would be available for the next meeting.

ACTION: FO

10.4. The committee urged caution when providing non-evidence based treatments at these events. An answer should be ready if required.

10.5. Members emphasised how important it was that managers had the skills to be able to discuss mental health issues and that support was in place for them to be able to have those conversations.

10.6. **The committee noted the paper outlining the activities implemented to improve employee health and wellbeing.**

11. Any other public business

11.1. There being no further business to discuss the public part of the meeting closed at 11:30.

Date of the next meeting:

TBC

Meeting paper

Council on Thursday, 8 November 2018

Public business

Council member remuneration

Purpose

To review remuneration rates for Council members

Recommendations

The Council is asked to:

i. agree that the remuneration for Council members, the Chair of Council and the discretionary payments for Chairs of the non-statutory committees (Audit and Risk, Remuneration and the Efficiency and Effectiveness Assurance and Advisory Group) should not be changed.

1. Introduction

1.1. The Remuneration Committee's remit includes advising the Council on the remuneration for Council members and the Chair. At its meeting in November 2017, the Council considered and approved the following changes to remuneration, effective from 01 April 2018:

a. Council member remuneration increase to £12,500 from £12,000;
b. Chair remuneration increase to £56,000 from £48,000;
c. discretionary payments for chairs of the Audit and Risk and Remuneration Committees increase to £2,500 from £2,000 [a discretionary payment of the same level is also made to the Chair of the Efficiency and Effectiveness Assurance and Advisory Group]

1.2. In making its decision, the Council considered the remuneration across the other healthcare professions regulators as well as the principles of fairness and transparency; comparability and affordability; and, market conditions, retention and motivation. The Council also noted that there had been no increase in rates of remuneration across the three areas since the GPhC was formed in 2010 and a significant recruitment drive to Council was imminent.

1.3. At that point, the Remuneration Committee agreed there should not be a major review of remuneration in 2018, given the changes approved in 2017. However, the Committee agreed that it should retain the option of a full review in light of any significant changes in the market or other relevant indicators in 2018.

2. Council member remuneration 2018

2.1 At its most recent meeting on 27 September 2018, the Remuneration Committee considered this issue and noted the current landscape for Council member remuneration across the healthcare professions regulators. This information is set out at tables A-C below. We have again included the equivalent estimated day rates although these rates are not precise, given the range of potential time commitments across the regulators. They are designed as an aid for comparison purposes only. However, we recognise that last year the Committee commented that breaking remuneration down into a daily rate for Council members may provide limited value as members hold public office for the duration of the term rather than being paid for activity on a day by day basis.

2.2 The Committee also noted that we are in the process of recruiting for five Council member vacancies arising in March 2019 using an open competition process. It is essential that remuneration rates remain competitive in order to attract the best candidates. There is also the ongoing need to ensure that as far as possible the levels of remuneration were sufficiently maintained to avoid having to make more significant increase to redress the balance at a future date.

2.3 Additionally, the Committee took account of important factors such as the likely views of stakeholders; our aim of being efficient and effective; our future ability to attract quality candidates; and, the potential to fall further behind our competitors over time. It also took into account the general principles underpinning our approach to remuneration.

Table A: Council member remuneration rates

Regulator	Council Member Allowance	Additional responsibilities	Time commitment	Equivalent Estimated Day Rate	Comments
GPhC	£12,500	+£2,500 for ARC, RemCom and EEAAG chairs	3 days per month	£350	Increased April 2018
NMC	£14,724	Nil	3 days per month	£368	Confirmed by email 17/09 - increased from last year
GOC	£13,595	£16,625 (senior)	4/5 days per month	£377	Extracted from annual report/website

GosC	£7,500	+£2,250 (for one Committee Chair)	Circa 18 days p.a. (1.5 per month)	£417	Confirmed by email 17/09
GCC	£6,650	None stated	15 days per year	£443	Reviewed in January 2016 – no change
GDC	£15,000	+£3,000 for committee chairs	2-3 days per month	£417	Extracted from annual report/website
GMC	£18,000		up to 3 days per month	£500	Confirmed by email 17/09
HCPC	£334 per day (assumed to be £11,800 at 36 days)		Attendance at 14 Council meetings + committee meetings (number not stated) and up to 6 days development	£334	Extracted from annual report/website

Table B: Chair remuneration rates

Regulator	Chair Allowance	Time commitment	Equivalent Estimated Day Rate	Comments
GPhC	£56,000	1-3 days per week	£543	Increased April 2018
GCC	£23,440	46 days per annum	£510	Reviewed February 17 – no change in rate but days reduced to 46 from 78
GDC	£55,000	100 days per annum	£550	Extracted from annual report/website
GMC	£110,000	Estimated 3 days per week	£705	Confirmed by email 17/09

GOC	£57,250	2-3 days per week	£440	Extracted from annual report/website
GOsC	£25,500	1-1.5 days per week	£392	Set for 01/04/16 to 31/03/20 Confirmed by email 17/09
HCPC	£58,250	156 days per annum	£373	Extracted from annual report/website
NMC	£78,000	3 days per week	£500	Confirmed by email 17/09

For external context, the Committee also noted that for August 2018 CPI was 2.5% and RPI 3.2%.

Table C: The mean and median remuneration across all the regulators compared with the GPhC
(Please note that the 2017 mean and median figures are marked in red)

Health Professions Regulators	**Mean (per annum)**	**Median (per annum)**	***GPhC***
Remuneration for Council Members[1]	£12,471 (£12,224)	£13,048 (£12,625)	*£12,500 pa* *(£12,000 pa)*
Additional remuneration for Chairs of Audit & Risk and Remuneration or other Committees	£2,695 (£2,570)	£2,750 (£2,570)	*£2,500 (£2,000) for Chairs of Audit & Risk and Remuneration Committees*
Remuneration for Council Chairs	£57,930 (£56,899)	£56,625 (£56,125)	*£56,000 pa* *(£48,000 pa)*

[1]This will fluctuate from year to year due to some Councils paying members a day rate with varying days undertaken per annum

Committee discussion

2.4 In making its recommendation this year, the Committee also explored whether remuneration had any effect on the recruitment of new Council members. It was explained that an executive search agency is assisting with this process and that no concerns had been raised by them or by the appointments panel to date. The Committee highlighted the balance to be struck between

appropriate remuneration for the role of Council member and the amount being intimidating to good candidates on lower salaries.

2.5 The Committee also discussed having a more comprehensive 'deep dive' into Council member remuneration every two years and agreed that this would be a good approach going forward.

2.6 Overall, the Committee agreed to recommend to the Council that there is no case this year for a substantive review of the remuneration for Council members, the Chair of Council and the discretionary payments for Chairs of the Audit and Risk and Remuneration Committee, and Efficiency and Effectives Assurance and Advisory Group, and that these should remain unchanged.

3. Equality and diversity implications

3.1. Remuneration should be set at a fair rate. Ensuring a fair rate of remuneration for the contribution of the groups covered by this paper will help ensure that the GPhC promotes equality and diversity.

4. Communications

4.1. The decisions arising from this paper will be considered at a future Council meeting. Council's remuneration including that of the Chair will be made available on the website and is detailed in the annual report.

5. Resource implications

5.1 Should the Committee decide to recommend to Council that current remuneration rates are maintained at the current level there will be no additional impact on budgets.

6. Risk implications

6.1 The risks for the GPhC in setting its remuneration policy are those of continuing to attract and retain high quality membership of the Council and its committees and advisory groups. At the same time both ensuring value for money and being able to respond to any adverse feedback from stakeholders.

Recommendations

The Council is asked to:

i. agree that the remuneration for Council members, the Chair of Council and the discretionary payments for Chairs of the non-statutory committees (Audit and Risk, Remuneration and the Efficiency and Effectiveness Assurance and Advisory Group) should not be changed.

Laura McClintock, Chief of Staff
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30 October 2018

Minutes of the **Audit and Risk Committee** meeting held on **Tuesday 23 October 2018** at 25 Canada Square, London at 10:30

TO BE CONFIRMED 23 JANUARY 2019

Minutes of the public session

Present

Digby Emson (Chair)

Helen Dearden

Mark Hammond

Mohammed Hussain

Jayne Salt

Apologies

None

In attendance

Duncan Rudkin (Chief Executive and Registrar)

Laura McClintock (Chief of Staff)

Tarun Chotai (Interim Head of Finance and Procurement)

Vanessa Clarke (Finance Manager)

Pascal Barras (Risk and Assurance Manager)

Bobbi Birk (Risk and Assurance Analyst)

Bill Mitchell (Moore Stephens)

Michelle Debique (Moore Stephens)

Matthew Hayday (Interim Director of Fitness to Practise) – Item 5

Janet Collins (Governance Manager)

1. Attendance and introductory remarks

1.1 The Chair welcomed those present to the meeting. There were no apologies.

2. Declarations of interest

2.1 Members were asked to declare any interests at the start of each item.

3. Minutes of the last meeting

3.1 Duncan Rudkin (DR) asked for the wording of paragraph 18.4 to be changed to state that the Register was a key tool for the organisation, rather than its key purpose.

The minutes of the public session of the meeting held on the 17 July 2018 were then agreed as a true record.

4. Actions and matters arising

4.1 Regarding action reference 24.30. from the meeting on the 25 October 2017, the assurance review on the integrity of the Register had not been finalised in time for the meeting due to staff personal issues. It would be circulated to the committee by email when issued.

ACTION: PB

4.2 DR gave an update on action 20.2. from the meeting on 17 Jul 2018. The action stated that the Committee had asked to see a critical path of data and insight work for the next 12 months, with milestones highlighted. DR said that although staff continued to work on both the planning and the carrying out of data and insight work, there was a need to ensure that the plan aligned with both the long-term vision and strategy and the 2019-20 business plan, both of which were still in production. Members were content with this approach.

ACTION: CBS

4.3 In reference to action 22.6 from the meeting on 17 July 2018, DR confirmed that the risks had been considered but, while it was possible in theory that the GPhC's use of data relating to pharmacy technicians could affect persons under 18 years of age, in reality the likelihood was negligible. This action was closed.

4.4 All other actions were in hand or due to be covered at this meeting.

5. Reserves policy

5.1 Tarun Chotai (TC) gave a presentation on the work being done on the reserves policy.

5.2 He explained that while reserves (either the net assets of an organisation or all liquid net assets – the 'free reserves') have traditionally been thought of as an insurance policy against risk, emerging thinking is that they can also be used for other purposes such as the pursuit of strategic opportunities and business development.

5.3 He proposed that the GPhC take a risk-based approach to reserves and took the committee through the approach, which would involve:

i base-lining a long term financial forecast;

ii carrying out a detailed analysis of long-term risk;

iii quantifying annual risk exposure; and

iv establishing a target reserve level and funding approach.

5.4 This work would be done alongside the current work on the budget. However, in order to assist with the budget work, an interim steer was needed on the minimum level of reserves that the committee would be comfortable with. On completion of the work on reserves, it would be brought back to the committee before the second round of the budgeting process.

5.5 Current and future risks identified by members included registrant numbers, statutory changes, income volatility, societal changes impacting on the delivery of pharmacy services, reputational damage and the intent to pursue charitable status.

5.6 The committee noted that it was difficult to have the new approach explained but then be asked to make a decision based on the current way of thinking.

5.7 **The Committee supported the further development of an analytical approach to the reserves policy and agreed that a figure of minimum 2.3 months' worth of reserves should be used in the initial budget round.**

6. Internal audit performance report 2018/19 Q2

6.1 Matthew Hayday (MHy) joined the meeting for this item. Pascal Barras (PB) presented **18.10.ARC.02** which provided a quarterly report to the committee on the progress of the Internal Audit Plan and the follow up of recommendations.

6.2 In comparison to 2017 when no audits had been completed by the end of Q2, in 2018 two out of six were complete or nearly complete and work on Q3 audits was on schedule. PB also highlighted that work was ongoing on six other audit areas compared to four last year.

6.3 The committee received the audit report on Fitness to Practise decision making and was pleased to note that it gave an overall assurance recommendation of Green.

6.4 A minor correction was required to the audit report, which referenced the Performance Services Authority instead of the Professional Standards Authority. MH clarified for the

committee that FtP does, in fact, accept anonymous concerns and takes action where possible.

6.5 There was also a minor correction to the paper where paragraph 3.2 should have made reference to 41 recommendations. There were four priority 1 recommendations which had not been implemented, all of which were covered in the audit action extension requests which had been provided to the committee.

6.6 The committee:

i. Noted Q2 2018/19 internal audit plan progress;

ii. Noted the outcone of the Fitness to Practise decision making audit and

iii. **Agreed to the extension requests.**

5.7 MH updated the group on the recommendations of the Lessons Learned Review published by the Department of Health and Social Care and the NHS in the wake of the Wannacry cyberattack, and the GPhC's response. A systematic process for patching had meant that the GPhC had not been vulnerable to the attack. While a number of the recommendations were not applicable to the organisation, three were highlighted:

i Under recommendation 1, it was noted that the GPhC is already compliant with the Cyber Essential plus standard;

ii Under recommendation 8, it was noted that a cyber-attack business continuity plan is being developed.

iii Under recommendation 10, it was noted that a Warning Advice and Reporting Point (WARP) group was being established with the other regulators.

5.8 Mohammed Hussain (MHn) commented that no community pharmacies had been affected by the Wannacry attack as they were not connected to the NHS network. With many pharmacies running antiquated IT systems, he suggested that there was a role for the GPhC in requiring a certain minimum level of cyber-security standards.

5.9 MHn also questioned, in light of the case of the Morrisons employee who had revealed the personal data of thousands of other employees online, whether the GPhC had systems in place to prevent the wilful exposure of data by employees. MH responded that access rights had been restricted and there were clear processes in place for starters and leavers which included ending access to data for employees who were leaving. In response to a suggestion from MHn, MH agreed to talk to the Head of IT about blocking and designing out USB ports on laptops.

5.10 The Chair noted that the upcoming IT security audit, due in Q3, should give added reassurance.

6. Raising concerns policy

6.1 LM presented **18.10.ARC.03.** The paper asked the committee to agree the revised raising concerns policy and recommend it to Council for approval and to provide feedback on further work to explore a new Freedom to Speak Up guardian or champion role.

6.2 The committee suggested that the section on the Public Interest Disclosure Act (2.3) could be moved to an annex or to the flowchart. DR also suggested that the 'introduction and purpose' section could also be more positively worded, linking to the work on organisational culture, staff should feel able to speak up.

6.3 It was agreed that the Chair of the EEAAG should also be included in step 3 of the policy and that the reference to Public Concern at Work as a source of advice and support for staff who had concerns could be more prominent

6.4 On the Guardian role, there was some discussion about whether it was better to have an internal or external person and also about the level at which the role should be pitched. It was agreed that the role would need to be properly resourced, supported and communicated to staff.

6.5 The committee

I. agreed the revised raising concerns policy with the amendments listed above and recommended this to Council; and

II. supported further exploratory work on the role of a Freedom to Speak Up Guardian or Champion.

7 Any other public business

7.1 There being no further public business to discuss, the meeting closed at 12.00.

Date of the next meeting:

Tuesday 23 January 2019