Meeting of Council  
Thursday, 08 September 2016  
11.45am to 4pm  
Council Room 1, 25 Canada Square, London E14 5LQ

Agenda

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| 5. Assessing the equality, diversity and inclusion impact of our policy development work | Duncan Rudkin  
Vivienne Murch |
| For discussion |
| 6. Registration Assessment and Board of Assessors’ Report – June 2016 | Damian Day |
| For discussion |
| 7. Consultation report on amendments to rules: indemnity and language competence | Rosalie Cus |
| For approval |
| 8. Draft guidance on evidence of English language skills and consultation report | Martha Pawluszyk |
| For approval |

Break for lunch

| 9. CPD Framework consultation | Osama Ammar |
| For approval |
| 10. Standards for pharmacy professionals consultation report | Priya Warner  
Andy Jaeger |
| For discussion |
| 11. Chief Executive and Registrar’s report | Duncan Rudkin |
| For noting |
12. Engagement and communications report
   For noting
   Rachael Oliver

13. Performance monitoring report
   For noting
   Duncan Rudkin

14. Audit and Risk Committee unconfirmed minutes of
    19 July 2016 public meeting
   For noting
   David Prince

15. Council member appointments 2017
   For approval
   Matthew Hayday

16. Any other public business
    Nigel Clarke

Confidential business

17. Declarations of interest
    Confidential items
    All

18. Minutes of last meeting
    Confidential session 07 July 2016
    Nigel Clarke

19. Actions and matters arising
    Nigel Clarke

20. Audit and Risk Committee unconfirmed minutes of
    19 July 2016 confidential meeting
    For noting
    David Prince

21. Review of strategic risks
    16.09.C.12
    Matthew Hayday

22. Any other confidential business
    Nigel Clarke

Date of next meeting
Thursday, 13 October 2016
Minutes of the Council meeting held on Thursday, 07 July 2016 at 25 Canada Square, London at 10am

TO BE CONFIRMED 9 SEPTEMBER 2016

Minutes of the public session

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

Apologies
Mary Elford
Liz Kay
Mohammed Hussain

In attendance
Duncan Rudkin (Chief Executive and Registrar)
Claire Bryce-Smith (Director of Inspection and Fitness to Practise)
Matthew Hayday (Head of Governance)
Vivienne Murch (Director of Organisational Development and Equality, Diversity and Inclusion)
Hugh Simpson (Director of Strategy)
Lyn Wibberley (Chief of Staff)
Elaine Mulingani (Associates and Partners Manager) items 1 to 5 only
Sue Reed (Council Secretary)

35. ATTENDANCE AND INTRODUCTORY REMARKS

35.1. The chair welcomed members and staff to the meeting.

36. DECLARATIONS OF INTEREST

36.1. The following interests were declared:
- **Item 5: Review of the Appointments Committee remit**
  Alan Kershaw and Samantha Quaye declared interests as members of an ad hoc panel set up with the sole remit of appointing a new Appointments Committee member to replace a retiring member.

37. **MINUTES OF LAST MEETING**

37.1. The minutes of the public session of the meeting held on 9 June 2016 were agreed as a true record.

38. **ACTIONS AND MATTERS ARISING**

38.1. Reference minute 81.3 of 10 December 2015 meeting: Council noted that the visual representation of the Investigating Committee's decision-making process had been circulated to Council on 7 July 2016.

38.2. Council noted that all other actions and matters arising would either be covered in the 7 July 2016 Council workshop or had been closed.

39. **REVIEW OF THE APPOINTMENTS COMMITTEE REMIT**

39.1. Elaine Mulingani presented 16.07.C.01 which asked Council to consider and, if appropriate, approve minor clarifications to the role and remit of the Appointments Committee (AC) and committee chair as set out in section 3 of the paper. Council was also asked whether any changes should be made to the current distribution of work between staff and committee members/the chair as outlined in section 4 of the paper.

39.2. Council agreed with a member’s proposal to extend the last term of reference of the AC Chair’s role to include a requirement to report whether or not the committees were operating in line with the GPhC’s values and policies.

39.3. Council:

(i) approved the minor clarifications to the role and remit of the Appointments Committee and committee chair as set out in section 3 of the paper, and in accordance with 39.2 above; and

(ii) confirmed no changes were necessary to the current distribution of work between staff and committee members/the chair as outlined in section 4 of the paper.

40. **ANY OTHER BUSINESS**

40.1. There being no further business, the meeting closed at 10.11am.

**DATE OF NEXT MEETING**

Thursday, 08 September 2016
Public business

Assessing the equality, diversity and inclusion impact of our policy development work

Purpose
To update Council on the GPhC’s approach to assessing the impact of our regulatory policy work in terms of equality, diversity and inclusion.

Recommendations
Council is asked to note – and to provide feedback on – our evolving approach to equality, diversity and inclusion impact assessment as part of the policy development process.

1. Introduction: our understanding of equality, diversity and inclusion (EDI)

1.1 Our commitment to equality encompasses and builds on our duty, as a public authority to:
- eliminate unlawful discrimination, harassment and victimisation and any other conduct outlawed under the Equality Act 2010
- advance equality of opportunity between people who share a legally protected characteristic and those who do not; and
- foster good relations between people who share a protected characteristic and those who do not

1.2 Our commitment to diversity is founded on our positive appreciation of the differences between people as a social good and as a business asset. The public whom we serve, and the professions with which we work, are themselves extraordinarily diverse. We see diversity in our organisation as a source of strength and innovation, with the potential to improve the quality and outcomes of what we do. In valuing diversity we appreciate the benefits that we as individuals and teams can gain from the fact that we all think and work in different ways.
1.3 Our commitment to **inclusion** 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. We aim in this way to take an inclusive approach to working with users of pharmacy services, registrants, stakeholders and indeed people affected in any way by our decisions, as well as our own GPhC workforce (in the widest sense).

1.4 Although this paper specifically focuses on the area of policy development, our commitment to a holistic approach to EDI extends across all we do and when we refer to embedding EDI we mean that it forms part of the fabric of the organisation.

1.5 However, as policy development underpins our regulatory work and processes it is important that we ensure that early thinking and ideas are shaped and influenced in the widest EDI context.

2. **Equality, diversity and inclusion impact assessment**

2.1 As we develop regulatory policy, there are a number of reasons why we need and want to record and make public our appreciation of the potential for the policy in question to present opportunities, risks and challenges to our equality, diversity and inclusion agenda.

2.2 First, the act of documenting our emerging assessment of the equality, diversity and inclusion impact of what we are proposing provides a useful internal discipline to ensure that these questions are asked as an integral part of the thought process that shapes our policy development and, more importantly, culture.

2.3 Secondly, an iterative ‘showing our workings’ approach will help our stakeholders to help us, in turn, by questioning whether we are considering relevant evidence, analysing it correctly and drawing valid conclusions about how a particular policy may support or otherwise our equality, diversity and inclusion agenda.

2.4 Thirdly, a public audit trail of our:

- preliminary scoping of equality, diversity and inclusion issues and relevant evidence
- challenge to and refinement of those preliminary thoughts and gathering of further evidence
- eventual conclusions based on sound evidence and analysis

will provide the Council and, through them, the public, with the necessary assurance that equality, diversity and inclusion issues, risks and opportunities have been properly taken into account throughout the policy development and approval cycle.
3. **Our evolving approach**

3.1 Council has made a positive commitment to its equality, diversity and inclusion agenda as reflecting and promoting core values of the organisation. It is therefore essential that the approach we take to assessing the equality, diversity and inclusion impact of policy development:

- is **not** formulaic, bureaucratic, preoccupied exclusively with negative impacts or peripheral to the ‘real’ policy agenda
- but is **integral** to our policy development culture and process, and demonstrably so.

For this reason we do not intend to adopt a rigid approach in terms of a set process but to adapt our assessment process according to the need and context, whilst maintaining the overall principles and approach outlined here. For example, what may be required by way of documentation is likely to be much fuller for a full statutory consultation on core standards than for a much smaller piece of work. We will apply consistently the principle that we will review EDI issues at key stages of the work and we will record and publish that evolving analysis, so that it can be tested and challenged by stakeholders and assurance provided to Council about that.

4. **Our evolving approach**

4.1 We are increasingly embedding our equality, diversity and inclusion work and thinking within our core activities and processes, as required by Council. At the same time we need to be able to identify and report on how we are approaching equality, diversity and inclusion issues in our work. Embedding does not mean obscuring.

4.2 Our approach recognises a number of key elements and phases in the equality, diversity and inclusion impact assessment process:
4.3 The assessment begins – and is documented – in the initial documentation (which might be a Council paper, for example) setting out the ‘business case’ for a piece of policy development work to be undertaken. Review is undertaken at each stage of the project life span as needed and a full review takes place as part of project closure. In this way Council has assurance and can hold the organisation to account throughout the life span of the project.

4.4 The evolving assessment is set out in draft consultation documents, giving Council the opportunity to assure itself that the right sorts of questions and evidence are being asked and sought. The iteratively refined assessment is then specifically referenced, alongside any other emerging themes in the analysis of consultation responses, and forms a visible part of the consultation response that Council is asked to agree as part of the final decision-making phase.

4.5 This approach marks a move away from an ‘EDI assessment’ as an ancillary process and document. The change is needed to re-position the way our people consider equality, diversity and inclusion issues throughout the policy development cycle, to ensure it is joined up rather than risking being an ‘add-on’. At the same time, the commitment to writing down our emerging assessment at key stages in key public documents will help ensure that there is a proper and accountable focus on identifying explicitly how our equality, diversity and inclusion agenda can be positively promoted as part of the piece of policy work, and any issues and risks appropriately mitigated and managed.
4.6 It is also intended that equality, diversity and inclusion assessment forms part of the regular review programme within the Governance team and is added to the internal audit programme.

5. Equality and diversity implications

5.1 The approach outlined will support and enhance our ongoing commitment to embed equality, diversity and inclusion at the heart of all we do.

6. Communications

6.1 Development sessions form part of our ongoing equality, diversity and inclusion programme. We are using these sessions to support our policy teams and staff to increase both confidence and ability in assessing equality, diversity and inclusion impact, with the aim of continually improving upon the quality of assessment undertaken and ensuring that the level of assessment undertaken is appropriate to the task in hand and fully supports the approach outlined in this paper.

7. Resource implications

7.1 No additional resource requirement is identified at this time.

8. Risk implications

8.1 Failure to adequately examine equality, diversity and inclusion implications within policy development could lead to: lost opportunities to identify beneficial impact; direct and/or indirect discrimination, and the implementation of a policy that is not fit for purpose.

9. Monitoring and review

9.1 The approach outlined in this paper will be scheduled for internal audit review as part of our regular internal audit planning, overseen by the Audit and Risk Committee.

Recommendations

Council is asked to note – and to provide feedback on – our evolving approach to equality, diversity and inclusion impact assessment as part of the policy development process.

Duncan Rudkin, Chief Executive and Registrar
Vivienne Murch, Director of Organisational Development and EDI
General Pharmaceutical Council
duncan.rudkin@pharmacyregulation.org 020 3713 7805
vivienne.murch@pharmacyregulation.org 020 3713 7804
23 August 2016
Council meeting 08 September 2016 16.09.C.02

Public business

Reporting on the June 2016 Registration Assessment

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

Recommendations
Council is asked to note:
(i) the Board of Assessor’s report to Council (Appendix 1) and to welcome the assurance it provides about the June 2016 sitting
(ii) candidate performance data and the discussion of issues of potential wider relevance in this report (Appendix 2)

1. Introduction
1.1 Passing the GPhC’s Registration Assessment is a pre-requisite for applying to register as a pharmacist\(^1\). There are two sittings every year, in June and September. This paper discusses the June 2016 sitting.

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

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

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

\(^1\) Except for EEA pharmacists.
2.2 **Policy on releasing Registration Assessment data:** Council has raised, through its strategic plan (2015–18), the importance of using information and knowledge gained from our regulatory services to support our statutory purposes. Consistent with this strategy we are now able to access and share increasing amounts of data about the Registration Assessment and to this end we have agreed a publication policy. After each sitting, a tranche of data will be included in a paper such as this to Council along with the Board’s report. The data released in this tranche are at Appendix 2. The second tranche will be released two weeks after the Council meeting at which the first is considered and will include aggregated performance data by pre-registration training provider and an anonymised list of all candidates and their marks for the two papers. This tranche is released later than the first so that the full candidate list can be adjusted to avoid identifying individuals and so that candidate data can be checked with training providers in advance of the release. Releasing two tranches of data a fortnight apart will be our standard practice from this sitting onwards.

2.3 All future data releases will be consistent with the Data Protection Act 1998 and Freedom of Information Act 2000, meaning that we will release as much data as possible while ensuring that what is presented preserves the anonymity of individuals. This may mean that some data are not reported.

2.4 **Higher pass rate:** at 95.3% the pass rate in June 2016 was high but not unprecedented: in 2012 the June pass rate was 94.5% and in 2008 it was 94.3%. As we have hypothesised before, candidate performance is multi-factorial and therefore difficult to interpret. While accepting that, the following factors may have influenced performance:

i. **Revising question types and standards setting:** as the Board explains in its report, question types have been revised so that only those that aid candidate comprehension are used. The Board has also introduced an additional layer of quality assurance – standards setters who are all practising pharmacists – to ensure that questions are suitable as possible for pre-registration trainees and early years pharmacists. In combination, these changes are likely to have influenced candidate performance positively.

ii. **A sustained communications campaign to raise awareness of the changes to the Registration Assessment:** in discussion with the Board, the GPhC agreed to devote a significant amount of time and resource to explaining the changes being made to the Registration Assessment this year. This began 18 months ago and has included seminars, the dissemination of documents about the changes by post, Twitter and our website and, latterly, a very well attended webinar. Given the level of engagement, we think it is reasonable to
assume that candidates were well informed about the change and that this may have influenced performance positively

iii. *Preparation by candidates, tutors and training providers:* this point is based on anecdote but strong anecdote. We have been made aware that some pre-reg training providers have invested more heavily in support for their trainees than in previous years, and some organisations have offered training courses and mock examinations that attracted significant numbers of trainees. On balance of probability, this is likely to have improved candidate performance

iv. *The cohort:* finally, we should not discount the possibility that the June cohort was a strong one, which is what the performance data suggests, and something that may explain a higher pass

2.5 *Trends:* as well as a higher pass rate, the performance of candidates by characteristics such as ethnicity, country of training and school of pharmacy has coalesced around narrower pass ranges but the underlying trends identified in previous years persist:

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

ii. hospital/industry trainees continue to out-perform their community counterparts

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

iv. candidates from some schools of pharmacy continue to outperform others, again with a broadly similar rank ordering

2.6 With another set of data, our understanding of performance in the Registration Assessment and pharmacist pre-registration training continues to improve but, inevitably, there is further work to be done before trends can be confirmed and assertions can be fully validated, particularly now that the format has changed. The trends commentary in 2.5 is presented with that in mind. We will consider how best to achieve a deeper understanding of our data internally and with our Council and the Board of Assessors.

3. **Equality and diversity implications**

3.1 Our trends observations in 2.5 and the data in Appendix 2 do present performance by protected characteristics in some instances and may have equality and diversity implications requiring further investigation, but not necessarily by the regulator.

3.2 We have considered the equality and diversity implications of Registration Assessment data in a number of previous reports over several years and when we have been able to identify issues we can explore further as the
regulator - such as the performance of Black-African candidates – we have taken action and will consider doing so again if other opportunities present themselves.

3.3 We hope that our openness with equality and diversity data and research will prompt education and training providers to consider what implications it may have for them.

4. Communications

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

5. Resource implications

5.1 There are no current resource implications for the GPhC.

6. Risk implications

6.1 There are no risk implications.

Recommendations

Council is asked to note:

(iii) the Board of Assessor’s report to Council (Appendix 1) and to welcome the assurance it provides about the June 2016 sitting

(i) candidate performance data and the discussion of issues of potential wider relevance in this report at Appendix 2

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

24 August 2016
1. Introduction

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

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

1.2 During pre-registration training, trainees are signed-off on four occasions by a designated pharmacist tutor – at 13, 26, 39 and 52 weeks. Trainees must have been signed off as ‘satisfactory’ or better at 39 weeks to be eligible to enter for a sitting of the Registration Assessment.

1.3 The Registration Assessment is an examination with two papers: part 1 (morning) and part 2 (afternoon). From the 2016 sittings, the Registration Assessment will be presented in a new format, which is discussed below.

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

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

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

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1 Non-EEA pharmacists wanting to register in GB take a one-year university Overseas Pharmacists’ Assessment Programme (OSPAP) instead of an MPharm degree.
1.7 Candidates with a specific need may ask for an adjustment to be made in the conduct of the assessment. Candidates with specific needs may sit the assessment in a separate adjustments room.

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 June 2016.

3. June 2016 summary statistics

<table>
<thead>
<tr>
<th>1. Candidate numbers</th>
<th>Number</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of candidates</td>
<td>2804</td>
<td>100%</td>
</tr>
<tr>
<td>Number of first sitting candidates</td>
<td>2614</td>
<td>93%</td>
</tr>
<tr>
<td>Number of second sitting candidates</td>
<td>102</td>
<td>4%</td>
</tr>
<tr>
<td>Number of third sitting candidates</td>
<td>88</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Candidate performance – pass rates</th>
<th>Number²</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall pass</td>
<td>2672</td>
<td>95%</td>
</tr>
<tr>
<td>Overall fail</td>
<td>131</td>
<td>5%</td>
</tr>
<tr>
<td>First sitting candidates - pass</td>
<td></td>
<td>96%</td>
</tr>
<tr>
<td>Second sitting candidates - pass</td>
<td></td>
<td>82%</td>
</tr>
<tr>
<td>Third sitting candidates - pass</td>
<td></td>
<td>87.5%</td>
</tr>
</tbody>
</table>

4. Paper and question analysis

Changes to the 2016 papers

4.1 For the last 2-3 years the Board has been developing a revised Registration Assessment with a far more patient-centred focus. This has been to reflect changes in the profession and to ensure that the Assessment remains fit for purpose. The first sitting using the new style was June 2016. This section summarises the change in brief (which are expanded upon at http://www.pharmacyregulation.org/the-registration-assessment).

4.2 Non-calculations questions: The papers for this sitting represented a significant departure from previous ones in that three question types used before were removed, one was retained and another was added. The change was made on the basis of evidence about the impact that question types had on comprehension and, linked to that, candidate performance.

² The results for one candidate have been withheld pending an investigation.
performance. The question type retained was single best answer and the question type added was extended matching (examples are on the GPhC’s website at http://www.pharmacyregulation.org/the-registration-assessment).

4.3 Calculations questions: Calculations questions were retained but in a separate paper – Part 1 - and candidates are now required to hand write their own answers, rather than selecting one from a pre-printed set. In addition to this, the use of calculators is now permitted in Part 1 for the first time. This allows question writers to make questions more realistic by setting questions about a variety of body sizes and weights that do not lend themselves easily to simple multiplication and division in longhand - that is, real people. Permitted calculator models were specified in advance and candidates reported no problems using them on the day.

Question performance

4.4 After the sitting the performance of all questions was analysed and across the two papers, performance was strong. Many questions had high pass rates and there were few that had to be considered by the Board on the basis of atypical performance.

4.5 In the Part 2 paper, candidates were divided about the answer to one question and significant numbers opted for either one of two options from the five provided. The Board agreed that there was some ambiguity in the question so it was removed. This had a minimal impact on the statistical reliability of the paper.

4.6 That so few questions were answered poorly suggests to the Board that the use of standards setters to evaluate questions before a sitting (see 5.2 below) has improved the overall quality of questions, which was high already.

4.7 Answers for Part 2 of the paper were selected by candidates who pencilled in a box next to a corresponding letter (as before) but numerical answers for Part 1 were entered by hand. Before the sitting the Board issued sample answer sheets and guidance on completing them so candidates knew what to expect. Unclear answers underwent a multi-stage scrutiny process, first by the marking contractor and then by GPhC staff, following an agreed protocol and escalation policy, so that the Board, as the final level of scrutiny, had to interpret only 20 unclear answers from a possible total of 448,640, equalling a final error rate of 0.004%. Nevertheless there is room for improvement and the board will issue guidance to candidates about completing answer sheets clearly to avoid ambiguity.

The balance of questions

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

Changes to the standards setting methodology

5.1 The standard of previous papers was set mainly by reusing some questions, known as reference questions, and by comparing the performance of those questions between cohorts. This enabled the Board to judge whether papers were comparatively difficult or easy or whether cohorts were comparatively strong or weak and to make judgements about the final pass mark based on an analysis of those variables. The target pass mark was set at 70% before every sitting but it was varied as appropriate on the basis of post-sitting performance data. While this method is reliable it does rely on benchmarking to questions which will, over time, become dated and will have to be removed from the question bank.

5.2 For the 2016 papers a different process was used, known as Angoff. In this method, and in the context of the Registration Assessment, a group of experts estimates the likely pass rate for each question in a paper and from that a pass mark is generated for each paper. Both papers have to be passed for a candidate to achieve a pass overall. The experts recruited for this exercise are standards setters, all of whom are practising pharmacists with first hand experience of early years/pre-registration trainees.

Pass marks and pass rates

5.3 The pass marks for the papers were: Part 1 – 65.5% and Part 2 – 61.3% respectively. These pass marks were set in advance by the standards setters and did not need to be adjusted after the sitting. Note that pass marks can vary depending on the difficulty of the papers: for example a more difficult paper might attract a lower pass mark and an easier paper a higher one, without the standard being altered.

5.4 The Board is aware that the overall pass rate for 95% is higher than in previous years but the new methodology was applied fully and accurately to the papers and the statistical performance evidence shows that candidates in the June 2016 did perform very well. Performance is multi-factorial and it may be the case that after extensive preparatory work by the Board and the GPhC, candidates may well have been particularly well prepared for this sitting. The Board will continue to monitor pass rates.
6. Feedback to candidates

Feedback for candidates will be incorporated into the usual November review of the online Preg-registration Training Manual and has been emailed to all confirmed September sitting candidates by the GPhC.

7. Feedback to the GPhC

It is the Board’s view that the experience of one sitting of the new style Registration Assessment is insufficient to provide detailed feedback to the GPhC, which it will do later in 2016 after the September sitting and after a period of discussion and reflection.

Professor Andrew Husband on behalf of the Board of Assessors
23rd August 2016
June 2016 Registration Assessment performance breakdown by characteristic

Table 1a: Overall performance

<table>
<thead>
<tr>
<th>No. of candidates</th>
<th>Overall Pass Rate</th>
<th>Total raw marks available</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Average % mark</td>
<td>Average % mark</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Raw mark (/40)</td>
<td>%</td>
</tr>
<tr>
<td>2804</td>
<td>95.3%</td>
<td>40</td>
<td>34.37</td>
<td>85.93</td>
</tr>
</tbody>
</table>

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

Table 1b: Paper pass mark

<table>
<thead>
<tr>
<th>Paper</th>
<th>Pass mark</th>
</tr>
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<tbody>
<tr>
<td>Part 1</td>
<td>65.5%</td>
</tr>
<tr>
<td>Part 2</td>
<td>61.3%</td>
</tr>
</tbody>
</table>

Note that the pass marks were set by the standards setters and are the standards candidates must reach in order to pass each paper. The pass marks may vary from paper to paper and year to year depending on the difficulty of questions and papers.

Note that the pass mark is the standard and the pass rate is the percentage of candidates who met the standard.

Referring to Table 1a, 95.3% of 2804 candidates gained at least 65.5% of the available marks in Part 1 and at least 61.3% of the available marks in Part 2 in order to pass.

Table 2: Performance by sitting attempt

<table>
<thead>
<tr>
<th>Sitting attempt</th>
<th>No. of candidates</th>
<th>Overall Pass Rate</th>
<th>Total raw marks available</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Average % mark</td>
<td>Average % mark</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Raw mark (/40)</td>
<td>%</td>
</tr>
<tr>
<td>1st</td>
<td>2614</td>
<td>96.10%</td>
<td>40</td>
<td>34.58</td>
<td>86.46</td>
</tr>
<tr>
<td>2nd</td>
<td>102</td>
<td>82.35%</td>
<td>40</td>
<td>31.26</td>
<td>78.16</td>
</tr>
<tr>
<td>3rd</td>
<td>88</td>
<td>87.50%</td>
<td>40</td>
<td>31.68</td>
<td>79.20</td>
</tr>
</tbody>
</table>
Note that data in Table 3 onwards are for 1st attempt sitters not the full cohort.

Table 3: 1st attempt by education route

<table>
<thead>
<tr>
<th>Education Route</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Part 1</td>
<td>Part 2</td>
</tr>
<tr>
<td>OSPAP</td>
<td>46</td>
<td>95.65%</td>
<td>86.79</td>
</tr>
<tr>
<td>MPharm</td>
<td>2568</td>
<td>96.11%</td>
<td>86.45</td>
</tr>
</tbody>
</table>

Table 4: 1st attempt by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Part 1</td>
<td>Part 2</td>
</tr>
<tr>
<td>Male</td>
<td>880</td>
<td>95.80%</td>
<td>87.17</td>
</tr>
<tr>
<td>Female</td>
<td>1734</td>
<td>96.25%</td>
<td>86.09</td>
</tr>
</tbody>
</table>

Table 5: 1st attempt by age range

<table>
<thead>
<tr>
<th>Age Range</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Part 1</td>
<td>Part 2</td>
</tr>
<tr>
<td>36 and over</td>
<td>62</td>
<td>82.26%</td>
<td>79.68</td>
</tr>
<tr>
<td>26-35</td>
<td>338</td>
<td>90.53%</td>
<td>82.63</td>
</tr>
<tr>
<td>25 or under</td>
<td>2214</td>
<td>97.34%</td>
<td>87.23</td>
</tr>
</tbody>
</table>

Table 6: 1st attempt by country of training

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Part 1</td>
<td>Part 2</td>
</tr>
<tr>
<td>Wales</td>
<td>97</td>
<td>100.00%</td>
<td>88.92</td>
</tr>
<tr>
<td>Scotland</td>
<td>170</td>
<td>99.41%</td>
<td>88.88</td>
</tr>
<tr>
<td>England</td>
<td>2345</td>
<td>95.69%</td>
<td>86.18</td>
</tr>
</tbody>
</table>
Table 7: 1st attempt by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academia/Industry</td>
<td>13</td>
<td>100.00%</td>
<td>89.62</td>
<td>82.37</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>704</td>
<td>99.15%</td>
<td>89.92</td>
<td>81.24</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>1897</td>
<td>94.94%</td>
<td>85.15</td>
<td>76.79</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: 1st attempt by ethnicity (≥ 75 candidates in a category)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average % mark</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Ethnic Group</td>
<td>75</td>
<td>92.00%</td>
<td>83.90</td>
<td>76.51</td>
<td></td>
</tr>
<tr>
<td>White - Other</td>
<td>75</td>
<td>97.33%</td>
<td>86.67</td>
<td>77.53</td>
<td></td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>76</td>
<td>94.74%</td>
<td>85.66</td>
<td>76.78</td>
<td></td>
</tr>
<tr>
<td>Asian - Other</td>
<td>173</td>
<td>97.11%</td>
<td>84.73</td>
<td>75.71</td>
<td></td>
</tr>
<tr>
<td>Black - African</td>
<td>233</td>
<td>87.98%</td>
<td>79.67</td>
<td>75.05</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>272</td>
<td>99.26%</td>
<td>90.23</td>
<td>78.22</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>316</td>
<td>95.57%</td>
<td>83.43</td>
<td>76.78</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>529</td>
<td>95.84%</td>
<td>85.62</td>
<td>77.56</td>
<td></td>
</tr>
<tr>
<td>White - British</td>
<td>620</td>
<td>98.87%</td>
<td>90.26</td>
<td>80.74</td>
<td></td>
</tr>
</tbody>
</table>
Table 9: MPharm degree 1st attempt by School of Pharmacy

<table>
<thead>
<tr>
<th>School of Pharmacy</th>
<th>No. of candidates</th>
<th>Pass Rate</th>
<th>Average %</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aston University</td>
<td>99</td>
<td>98.99%</td>
<td>89.44</td>
<td>81.66</td>
<td></td>
</tr>
<tr>
<td>University of Bath</td>
<td>96</td>
<td>100.00%</td>
<td>91.98</td>
<td>80.56</td>
<td></td>
</tr>
<tr>
<td>University of Bradford (4-year degree)</td>
<td>69</td>
<td>91.30%</td>
<td>82.93</td>
<td>76.97</td>
<td></td>
</tr>
<tr>
<td>University of Bradford (5-year sandwich)</td>
<td>72</td>
<td>91.67%</td>
<td>83.47</td>
<td>77.31</td>
<td></td>
</tr>
<tr>
<td>University of Brighton</td>
<td>111</td>
<td>90.09%</td>
<td>81.46</td>
<td>74.81</td>
<td></td>
</tr>
<tr>
<td>Cardiff University</td>
<td>107</td>
<td>100.00%</td>
<td>89.53</td>
<td>78.26</td>
<td></td>
</tr>
<tr>
<td>University of Central Lancashire</td>
<td>72</td>
<td>86.11%</td>
<td>81.32</td>
<td>74.94</td>
<td></td>
</tr>
<tr>
<td>De Montfort University</td>
<td>94</td>
<td>100.00%</td>
<td>86.09</td>
<td>80.12</td>
<td></td>
</tr>
<tr>
<td>University of East Anglia</td>
<td>85</td>
<td>98.82%</td>
<td>88.82</td>
<td>78.68</td>
<td></td>
</tr>
<tr>
<td>University of Hertfordshire</td>
<td>155</td>
<td>92.90%</td>
<td>83.02</td>
<td>74.60</td>
<td></td>
</tr>
<tr>
<td>University of Huddersfield</td>
<td>54</td>
<td>90.74%</td>
<td>85.00</td>
<td>76.06</td>
<td></td>
</tr>
<tr>
<td>Keele University</td>
<td>71</td>
<td>97.18%</td>
<td>88.06</td>
<td>78.31</td>
<td></td>
</tr>
<tr>
<td>King’s College London</td>
<td>89</td>
<td>100.00%</td>
<td>86.24</td>
<td>78.20</td>
<td></td>
</tr>
<tr>
<td>Kingston University</td>
<td>90</td>
<td>87.78%</td>
<td>80.36</td>
<td>73.40</td>
<td></td>
</tr>
<tr>
<td>Liverpool John Moores University</td>
<td>104</td>
<td>98.08%</td>
<td>88.89</td>
<td>79.94</td>
<td></td>
</tr>
<tr>
<td>University of Manchester</td>
<td>110</td>
<td>98.18%</td>
<td>87.25</td>
<td>79.10</td>
<td></td>
</tr>
<tr>
<td>Medway School of Pharmacy (universities of Greenwich and Kent)</td>
<td>134</td>
<td>97.01%</td>
<td>84.85</td>
<td>78.21</td>
<td></td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>223</td>
<td>98.65%</td>
<td>90.22</td>
<td>78.63</td>
<td></td>
</tr>
<tr>
<td>University of Portsmouth</td>
<td>101</td>
<td>92.08%</td>
<td>82.97</td>
<td>74.98</td>
<td></td>
</tr>
<tr>
<td>University of Reading</td>
<td>110</td>
<td>95.45%</td>
<td>85.80</td>
<td>76.79</td>
<td></td>
</tr>
<tr>
<td>The Robert Gordon University</td>
<td>92</td>
<td>97.83%</td>
<td>87.99</td>
<td>77.68</td>
<td></td>
</tr>
<tr>
<td>University of Strathclyde</td>
<td>135</td>
<td>98.52%</td>
<td>88.43</td>
<td>80.07</td>
<td></td>
</tr>
<tr>
<td>University of Sunderland</td>
<td>94</td>
<td>97.87%</td>
<td>88.27</td>
<td>82.01</td>
<td></td>
</tr>
<tr>
<td>University College London</td>
<td>140</td>
<td>97.86%</td>
<td>86.98</td>
<td>78.64</td>
<td></td>
</tr>
<tr>
<td>University of Wolverhampton</td>
<td>53</td>
<td>94.34%</td>
<td>84.58</td>
<td>77.96</td>
<td></td>
</tr>
</tbody>
</table>

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

Consultation report on amendments to rules: indemnity and language competence

Purpose
To provide Council with a final draft of rules amending the GPhC’s Registration Rules, Fitness to Practise and Disqualification Rules, and Statutory Committees and their Advisers Rules, and a draft report on the consultation on these changes.

Recommendations
Council is asked to:
(i) approve the draft report of the consultation on amendments to rules for publication (Appendix 1)
(ii) make the GPhC (Amendment of Miscellaneous Provisions) Rules 2016 (Appendix 2) and agree that the GPhC’s corporate seal be affixed to these rules

1. Introduction
1.1 The Health Care and Associated Professions (Indemnity Arrangements) Order (SI 2014/1887) was made in 2014. It amended the Pharmacy Order 2010 so as to implement a requirement for practising health professionals to have insurance or indemnity arrangements as a condition of registration. It also implemented article 4(2)(d) of Directive 2011/24/EC requiring member states to have in place systems of professional liability cover or similar in respect of cross-border healthcare for patients receiving treatment in their member state.

1.2 The Health Care and Associated Professions (Knowledge of English) Order (SI 2015/806) was made in March 2015. It amended the Pharmacy Order to strengthen the GPhC’s powers to introduce fair and proportionate language controls and to require EU applicants to provide evidence of their knowledge of the English language, following recognition of their professional qualification but before registration.
1.3 Council approved draft amendments to rules for consultation in September 2015. The consultation ran for 12 weeks and closed on 17 December 2015. The responses are summarised in the draft report at Appendix 1.

1.4 The main purpose of the proposals is to amend the Registration Rules and Fitness to Practise and Disqualification Rules to take account of changes to the Pharmacy Order 2010 concerning requirements for indemnity arrangements and for knowledge of the English language. In addition, some changes would be made which were requested previously by parliamentary subordinate legislation committees. These relate to:

- avoiding conflicts of interest arising from common membership of Fitness to Practise Committee panels and Appeals Committee panels; and
- avoiding breach of Crown copyright relating to the front cover of a UK passport.

1.5 The responses received were generally supportive and it is proposed that Council goes ahead with the proposed amendments to rules. A final draft of the amendments rules is at Appendix 2. This has been cleared with the Privy Council’s advisers (Department of Health policy officials and solicitors). After making, the rules would be submitted to ministers and laid in the UK and Scottish Parliaments. Once the laying period has passed, they would come into force.

1.6 The Privy Council Office has advised that the rules will likely be laid in both parliaments in the week commencing 24 October 2016. If laying does occur that week then the rules will come into force towards the end of November 2016.

2. Equality and diversity implications

2.1 An equality analysis of the draft rules was published on the GPhC website during the consultation. The areas of consideration included race and disability.

2.2 The analysis considered, amongst other issues, that the proposed changes to rules relating to the new statutory requirement to have the necessary knowledge of English were likely to affect European pharmacists and pharmacy technicians. They would be required to pay for a language test or be prevented from practising in Great Britain if their knowledge of English was not at the required level. However, this would address the current disparity between the controls relating to the language competence of European pharmacy professionals and those from outside the EEA, who were already subject to such controls. This should provide a more consistent approach and enhance patient safety.
2.3 No further equality and diversity implications have been identified arising from the proposed amendments during the consultation. Full details of those originally identified can be seen in the equality analysis.

3. Communications implications

3.1 The consultation report and the final version of the rules will be published on the GPhC’s website. Once the rules come into effect, the new requirements and guidance relating to knowledge of English will be promoted to key audiences including registrants, students and trainees and patients and the public through national, local and pharmacy media, social media, a targeted email campaign, Regulate and other appropriate communications channels. Through these communications we aim to make registrants and potential future applicants aware of the new requirements and to give assurance to patients and the public that pharmacy professionals will have to demonstrate that they have the necessary knowledge of English to practise safely and effectively. We will also publish FAQs on our website to provide guidance to registrants and employers on indemnity requirements. We will promote these FAQs via Regulate and social media and through communications to new and current registrants.

4. Resource implications

4.1 There are no significant resource implications involved in making the rules.

5. Risk implications

5.1 If the amendments rules are not made, this would delay full implementation of the statutory changes concerning requirements for indemnity arrangements and for knowledge of the English language.

Recommendations

Council is asked to:

(i) approve the draft report of the consultation on draft amendments to rules for publication (Appendix 1)

(ii) make the GPhC (Amendment of Miscellaneous Provisions) Rules 2016 (Appendix 2) and agree that the GPhC’s corporate seal be affixed to these rules

Rosalie Cus, Senior Legal Adviser
General Pharmaceutical Council
rosalie.cus@pharmacyregulation.org
020 3713 7830

23 August 2016
DRAFT

Consultation report: amendments to rules

The GPhC (Registration) Rules 2010
The GPhC (Fitness to Practise and Disqualification etc.) Rules 2010, and
The GPhC (Statutory Committees and their Advisers) Rules 2010

August 2016
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Consultation report on amendments to rules

Summary

1. The General Pharmaceutical Council (‘GPhC’) is the independent regulator for pharmacists, pharmacy technicians and registered pharmacies in Great Britain.

2. In late 2015, we consulted on changes to some of our rules. The main purpose of these proposals was to implement the statutory requirements for a registrant to have an appropriate indemnity arrangement in force and to have the knowledge of English necessary for safe and effective practice, as conditions of their registration with us. The changes would also introduce measures to avoid conflicts of interest arising from common membership of Appeals Committee and Fitness to Practise Committee panels. We consulted on amendments to the following rules:
   - The General Pharmaceutical Council (Registration) Rules 2010 (SI 2010/1617)
   - The General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010 (SI 2010/1615)
   - The General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010 (SI 2010/1616)

3. This report provides a summary of the responses to the consultation and a commentary in relation to our proposals.

4. The responses we received were broadly supportive, and we have decided to go ahead with the proposed changes.

5. We are grateful for the feedback we have received. We will continue to keep the content of our rules under review.

6. Alongside the consultation on amendments to rules, we consulted on draft guidance about the evidence, information and documents that may be provided by an applicant or registrant for the purpose of satisfying the registrar that they have the necessary knowledge of English, and the process by which the registrar will determine whether he is satisfied that the person has this knowledge. The report of that consultation can be found here [insert link].
1. **Background**

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacies in Great Britain. It is our job to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmacy services in England, Scotland and Wales.

We regulate pharmacists and pharmacy technicians in community and hospital settings. We also regulate practice within academia, research, public health, commissioning, management, industry and other settings where the public rely indirectly, but no less significantly, on the professionalism and competence of pharmacy professionals in a wide range of non-clinical roles. We also set standards for registered pharmacies.

Our core functions include:

- setting the standards of education and training which pharmacists and pharmacy technicians must meet in order to join our register and remain registered throughout their professional life
- registering pharmacists and pharmacy technicians and setting the standards of conduct and performance which they must meet to stay on our register
- setting standards for the safe and effective practice of pharmacy at registered pharmacies
- registering pharmacies which meet those standards and inspecting them to check that they continue to do so
- taking action when our standards are not met, typically through fitness to practise proceedings and enforcement action

We aim to make sure that regulation is fair and proportionate – taking into account the risk posed to public health, safety and wellbeing – and not over-burdensome. We want it to be flexible enough to respond to the changing demands made of the profession by governments on behalf of the public, and allow for innovation, while at the same time maintaining high quality practice.

The main pieces of legislation governing the GPhC are the Pharmacy Order 2010 (SI 2010/231) and the Medicines Act 1968 (c. 67). More detailed provisions relating to our regulatory functions are set out in statutory instruments called ‘rules’.

We consulted on proposed amendments to the following rules:

The General Pharmaceutical Council (Registration) Rules 2010 (SI 2010/1617)
The main purpose of these proposals was to implement the statutory requirements for a registrar to have an appropriate indemnity arrangement in force and to have the knowledge of English necessary for safe and effective practice, as conditions of their registration with us. The changes would also introduce measures to avoid conflicts of interest arising from common membership of Appeals Committee and Fitness to Practise Committee panels.

Further information about the work of the GPhC can be found on our website [www.pharmacyregulation.org](http://www.pharmacyregulation.org)

**About this report**

This report provides a summary of the responses to the consultation on draft amendments to rules held between 24 September and 17 December 2015.

The report provides background to the consultation, a breakdown of the responses to our proposals and a commentary on the responses. We recommend that the statistical information on the responses is read in conjunction with the commentary. Appendix 1 provides a list of organisations that responded to the consultation.

**Responses to the consultation**

We received 73 responses to the consultation. In analysing the responses, we have calculated percentages to 0.1 of a decimal point, which means that the total may be fractionally more or less than a hundred in some cases.

<table>
<thead>
<tr>
<th>Respondents by type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>33</td>
<td>45.2%</td>
</tr>
<tr>
<td>Organisation</td>
<td>9</td>
<td>12.3%</td>
</tr>
<tr>
<td>Skipped question</td>
<td>31</td>
<td>42.4%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
</tr>
<tr>
<td>Individual type</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
</tbody>
</table>
| A pharmacy professional         | 27    | 37.0%
| A member of the public          | 5     | 6.8%
| Other                           | 0     | 0.0%
| Skipped question                | 41    | 56.1%
| Total                           | 73    | 100% |

<table>
<thead>
<tr>
<th>Pharmacy professional type</th>
<th></th>
<th>%</th>
</tr>
</thead>
</table>
| Pharmacist                      | 23    | 31.5%
| Pharmacy technician             | 3     | 4.1%
| Skipped question                | 47    | 64.4%
| Total                           | 73    | 100% |

<table>
<thead>
<tr>
<th>Respondents by country</th>
<th></th>
<th>%</th>
</tr>
</thead>
</table>
| England                         | 22    | 30.1%
| Scotland                        | 1     | 1.4%
| Wales                           | 2     | 2.7%
| Northern Ireland                | 0     | 0.0%
| Other                           | 3     | 4.1%
| Skipped question                | 45    | 61.7%
| Total                           | 73    | 100% |

<table>
<thead>
<tr>
<th>Areas worked in</th>
<th></th>
<th>%</th>
</tr>
</thead>
</table>
| Community pharmacy              | 11    | 15.1%
<p>| Hospital pharmacy               | 6     | 8.2%  |</p>
<table>
<thead>
<tr>
<th>Primary care organisation</th>
<th>0</th>
<th>0.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy education and training</td>
<td>8</td>
<td>11.0%</td>
</tr>
<tr>
<td>Pharmaceutical industry</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.7%</td>
</tr>
<tr>
<td>Skipped question</td>
<td>46</td>
<td>63.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>73</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Respondents working in community pharmacy**

<table>
<thead>
<tr>
<th>Pharmacy owner</th>
<th>1</th>
<th>1.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>11</td>
<td>15.1%</td>
</tr>
<tr>
<td>Self-employed locum</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>Skipped question</td>
<td>58</td>
<td>79.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>73</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Organisation type**

<table>
<thead>
<tr>
<th>Pharmacy organisation</th>
<th>6</th>
<th>8.2%</th>
</tr>
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<tbody>
<tr>
<td>Non-pharmacy organisation</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>73</strong></td>
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</tr>
</tbody>
</table>
2. Indemnity arrangements

2.1 The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 ("Indemnity Arrangements Order") amended the Pharmacy Order 2010 so as to implement a requirement across health professions for practising health professionals to have insurance or indemnity arrangements as a condition of registration. It also implemented article 4(2)(d) of Directive 2011/24/EC requiring member states to have systems of professional liability cover or similar in place in respect of cross-border healthcare for patients receiving treatment in their member state.

2.2 The requirement for pharmacists and pharmacy technicians to have indemnity cover is not new. Registrants were already under an obligation, under article 32 of the Pharmacy Order, to have appropriate indemnity cover in force.

2.3 Article 32 of the Pharmacy Order sets out that an indemnity arrangement may be: an insurance policy; an arrangement made for the purposes of indemnifying a person, for example by an employer, or a combination of the two. ‘Appropriate cover’ means cover against liabilities that may be incurred in practising as a pharmacist or pharmacy technician which is appropriate, having regard to the nature and extent of the risks of practising as such. This cover must be in force by the time the person begins to practise (rather than, as previously, on the date of registration). Article 32 also enables the GPhC to make rules concerning the information to be provided to the registrar for the purposes of determining whether there is, or will be, an indemnity arrangement in force which provides appropriate cover in relation to that person.

2.4 The indemnity requirements do not apply to visiting pharmacists or pharmacy technicians from relevant European states. Visiting practitioners are required to provide a declaration which includes details of the indemnity arrangements they have in place. They are registered in part 4 (for visiting pharmacists) or part 5 (for visiting pharmacy technicians) of our register based on their legal establishment in their home member state.

2.5 The Indemnity Arrangements Order made some consequential amendments to the Registration Rules. The amendments proposed to the rules here build on these to set out in more detail the information to be provided by applicants or registrants and the action that may be taken if a registrant does not comply with the indemnity requirements.

3. Knowledge of English

3.1 The Health Care and Associated Professions (Knowledge of English) Order 2015 (‘Knowledge of English Order’) amends the Pharmacy Order to strengthen the GPhC’s
powers by introducing fair and proportionate language controls and to require EU applicants to provide evidence of their knowledge of the English language, following recognition of their professional qualification but before registration.

3.2 The Knowledge of English Order requires the GPhC to consult on and publish guidance setting out the evidence, information or documents that an applicant or registrant may provide to demonstrate that they have the necessary knowledge of English for safe and effective practice as a pharmacist or a pharmacy technician. We consulted on this draft guidance alongside the consultation on changes to our rules. The consultation report on the guidance can be found here [link].

3.3 The requirement to have the necessary knowledge of English for safe and effective practice applies to all applicants and registrants. Any person who is refused registration on the grounds that they have failed to satisfy the registrar that they have the necessary knowledge of English will have a right of appeal.

3.4 The Knowledge of English Order creates a new category of impairment of fitness to practise relating to competence in the English language. This will allow us to initiate fitness to practise proceedings in cases where a pharmacy professional’s knowledge of the English language may pose a serious risk to patient safety.

4. Amendments to the GPhC Statutory Committees and their Advisers Rules

4.1 This section covers amendments to The General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010 (SI 2010/1616).

Common membership of Fitness to Practise Committee and Appeals Committee panels

What we proposed

4.2 We proposed amending the rules to avoid conflicts of interest arising from common membership of Appeals Committee and Fitness to Practise Committee panels.

4.3 The GPhC has three statutory committees:

Investigating Committee – this committee considers allegations that a registrant’s fitness to practise is impaired and decides whether to refer the case to the Fitness to Practise Committee for a full inquiry. The committee can also consider whether the GPhC should institute criminal proceedings under any of its enforcement powers.
**Fitness to Practise Committee** - this committee makes decisions in cases where a registrant’s fitness to practise may be impaired. It also considers allegations that a pharmacy owner should be disqualified and that pharmacy premises should be removed from the register.

**Appeals Committee** – this committee considers appeals against decisions relating to registration or to approval of education providers, as listed in article 39 of the Pharmacy Order.

4.4 The Statutory Committees and their Advisers Rules allow persons to be members of both the Fitness to Practise Committee (FtPC) and the Appeals Committee. These committees also share a list of reserve panellists. This provides flexibility and helps panellists to maintain their skills but it is possible that potential conflicts of interest could arise from common membership of the committees’ panels i.e. if the same person or persons served on both a FtPC panel and an Appeals Committee panel to consider the same matters. We proposed amending the rules to prevent this happening.

4.5 There are a few situations where the Appeals Committee and the FtPC could be considering the same issues:

- The Appeals Committee may request advice from the FtPC under rule 9(1)(d) of the Appeals Committee Rules (S.I.2010/1614)

- The registrar may seek the advice of the FtPC about the fitness to practise of an applicant for registration (Registration Rules 10(8) & (10)). The FtPC would not make the final decision on the application but would advise the registrar, who would then decide whether to grant the application. If the registrar refused the application, the applicant could appeal that decision to the Appeals Committee (art 39(1)(b), Pharmacy Order)

- The registrar may determine that a registrant’s entry in the register has been fraudulently procured or incorrectly made (art 29(3), Pharmacy Order) and remove the entry accordingly. A registrant’s entry may also be removed if their fitness to practise was impaired at the time the entry was made (art 30, Pharmacy Order). Under rules 19 and 20 of the Registration Rules, a registrant on whom a Notice of Intention to Remove [from the register] has been served may request a hearing. If a hearing is requested, the registrar must refer the matter to the FtPC. The FtPC would make findings of fact and advise the registrar but it is the registrar who would decide whether to remove the person from the register. The registrar’s decision could then be appealed to the Appeals Committee (art 39(1)(i)-(j), Pharmacy Order)

**What we heard**

**Question 1** - Do you agree with the proposal to prevent common membership of Fitness to Practise and Appeals Committee panels where this could give rise to a conflict of
<table>
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<th>interest?</th>
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<tbody>
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<tr>
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<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
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</table>

4.6 85% of respondents agreed with this proposal and 4.1% disagreed. 11% of respondents stated that they did not know.

4.7 Comments made included that this change would strengthen the credibility of the committees’ decisions and would be appropriate to ensure a transparent process and make any appeal independent of the original decision-making body.

4.8 One comment indicated that this would depend on the situation and the particular conflict of interest. Another said that where a member had not been involved previously, they should be allowed to sit. The proposed change would allow a member who had not been involved previously to sit on an Appeals Committee panel. However, where a member had sat on a Fitness to Practise Committee panel that had given advice on, or made findings of fact in relation to, a particular matter, they would not be able to sit on an Appeals Committee panel in connection with that matter.

**Our response**

4.9 We propose to go ahead and amend the Statutory Committees and their Advisers Rules to prevent common membership of Fitness to Practise Committee and Appeals Committee panels where this could give rise to a potential conflict of interest.

**5. Amendments to the GPhC Registration Rules**

5.1 This section covers amendments to The General Pharmaceutical Council (Registration) Rules 2010 (S.I. 2010/1617). Most of the changes we proposed were to implement the requirements for a registrant to have an appropriate indemnity arrangement in force and to have the knowledge of English necessary for safe and effective practice, as conditions of their registration with us.

**Duty to provide information about indemnity arrangements: registrants**

**What we proposed**
5.2 We proposed inserting a new rule 8A in the Registration Rules requiring registrants, on receipt of a notice from the registrar, to provide information for the purposes of determining whether an indemnity arrangement is in force which provides appropriate cover in relation to them. The information would need to be provided within seven days of the date of the notice but that period could be longer if that was reasonable in the circumstances. If a registrant did not provide the information required about their indemnity cover, the registrar would be able to: refuse to renew their registration; remove their entry from the register, or treat the failure as misconduct for fitness to practise purposes. All registrants would have to inform the registrar within seven days if they ceased to have an appropriate indemnity arrangement in force.

What we heard

<table>
<thead>
<tr>
<th>Question 2 - Do you agree with the proposed duty for registrants to provide information about their indemnity arrangements?</th>
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<tr>
<td>Yes</td>
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<tr>
<td>No</td>
</tr>
<tr>
<td>Don’t know</td>
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<tr>
<td>Skipped question</td>
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<td>Total</td>
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5.3 49.3% of respondents agreed with this proposal and 24.7% disagreed. 26% of respondents chose not to respond to this question or stated that they did not know.

5.4 Some respondents suggested that not all registrants needed an indemnity arrangement as their employer provided indemnity cover for them. Another requested guidance on this point. Others suggested that some registrants, such as those working in academia or government, may not require indemnity cover because of the nature of their work. Another sought guidance on the requirements for a registrant who was practising overseas.

5.5 Two pharmacy organisations raised concerns about the potential need for a registrant to provide information about their indemnity arrangements within seven days, if required. One expressed concern that an NHS employee may be unable to obtain evidence of indemnity cover from their employer within seven days, and asked whether an NHS job description would be sufficient evidence, on the basis that the employer’s vicarious liability should be sufficient for a pharmacy professional employed by an NHS body and undertaking the duties detailed in their job description. Another organisation queried a registrant’s ability to meet a seven-day deadline if, for example, they were on holiday. This organisation also suggested that, if a request for evidence of indemnity cover was made together with the annual renewal notice, this
would effectively mean that the registrant would need to apply for renewal within seven days, which could raise cash flow issues for contractors.

5.6 A pharmacy organisation queried whether each employed registrant would need to submit a copy of their employer’s indemnity cover, and commented that there was no indication of how frequently this would be requested.

5.7 The same organisation asked whether, if a registrant left an employer and took a period of unpaid leave before starting another job, they would need to inform the registrar that they did not have indemnity cover during this period and could potentially be removed from the register. They believed that this depended upon the definition of ‘practising’ and asked that this be set out, querying whether a registrant should refuse a friend’s request for advice during a period when they were between employers and did not have indemnity cover.

5.8 Another pharmacy organisation expressed support for the GPhC’s duty to implement statutory requirements in relation to indemnity arrangements and knowledge of English. It was keen to avoid ambiguity in the requirements and to ensure they could be met using existing systems and processes, so that they would not be over-burdensome. They sought clarification:
- that registrants would not be routinely required to produce evidence of indemnity arrangements within seven days as part of the annual renewal process
- that at the time of renewal, registrants would be required to specify whether they have, or will have, appropriate indemnity arrangements in place, and that they have evidence, information or documents demonstrating the necessary knowledge of English, using a self-declaration
- on the circumstances in which registrants may be removed from the register if appropriate indemnity cover is not in place, to avoid a situation where a registrant may be removed from the register simply because they are not currently practising and therefore may not have indemnity arrangements in place

5.9 Another pharmacy organisation supported the proposals, considering them to be necessary as proposed.

5.10 One respondent asked about evidence to show that imposing indemnity requirements on registrants would have an impact on patient safety.

5.11 Another pharmacy organisation, whilst not opposing the majority of the proposals, raised some questions and concerns:
- whether registrants and indemnity providers would need to retain historical proof of indemnity cover indefinitely, in case it was requested by the registrar
- whether a registrant would be able to have sight of their employer’s professional indemnity insurance certificate and policy, in order to satisfy themselves as to whether their employer’s cover was sufficient for them. They recommended that
employers be required to provide employees with sight of their professional indemnity insurance certificate
• the potential for cover under an employer’s professional indemnity policy to be conditional on whether the employee had followed the employer’s legal or other advice, or whether the employer had identified a performance issue with the employee
• whether particular types of indemnity arrangements would provide appropriate cover for registrants

5.12 An arrangement or factor mentioned as potentially affecting the appropriateness of a particular indemnity arrangement for a registrant was Contingent Medical Malpractice cover, which relies on an employer having primary medical malpractice insurance and primary public liability cover in place, with the Contingent Medical Malpractice cover coming into operation if the employer’s primary cover fails. Also mentioned was an arrangement whereby an employer agrees with a professional indemnity insurance provider to settle claims up to a certain value. The organisation recommended that guidance be provided to registrants and employers about the suitability and minimum acceptable specification of indemnity insurance cover.

Our response

5.13 Registrants are already obliged, under the Pharmacy Order and the GPhC’s standards, to have appropriate indemnity arrangements in place. The proposed amendments to rules would set out in more detail the information that applicants or registrants may need to provide and the action that may be taken if a registrant does not comply with the indemnity requirements. The majority of registrants would simply confirm that they continue to meet the requirements for both indemnity arrangements and knowledge of English, by making a self-declaration when renewing their registration.

5.14 The rules would allow the registrar to issue a notice requiring a registrant to provide information about their indemnity arrangements. The period within which the information must be provided would be stated in the notice but would not be less than seven days. We propose to adjust the wording of the rules to make clear that seven days would be a minimum period – not a standard deadline. The minimum period of seven days was chosen on the basis that we may need to act promptly to protect the public, for example if concerns were raised that someone was practising without indemnity cover and patients could be at risk. This would also be in line with the seven day period within which registrants must inform the registrar of any specified event that may affect their fitness to practise, such as convictions or cautions (rule 4, Fitness to Practise and Disqualification etc Rules). We intend to take a proportionate and risk-based approach, using this minimum period only when we consider it necessary for public protection.

5.15 We would not request evidence of indemnity cover from registrants on a routine basis but we may seek such evidence on occasion, for example when a complaint has been
made or when there are concerns that appropriate cover may not be in place. There would be no requirement to provide evidence of indemnity cover as part of the standard renewal process. The renewal process would require a self-declaration. If it happened that we needed to seek evidence of indemnity cover from a registrant during their renewal period (for example, because concerns had been raised that they did not have cover in place), the notice requesting this information would be sent separately from the renewal notice and would state the deadline for providing this information.

5.16 It would be the responsibility of an individual registrant to provide information about their indemnity cover if required, not their employer. However, it would not be necessary for every employed registrant to submit a copy of their employer’s indemnity cover – this would only need to be provided by an individual registrant on request.

5.17 The rules would also allow the registrar to require registrants to provide evidence of indemnity cover from past periods. Again, we intend to take a reasonable and proportionate approach to making such requests. We would not expect registrants to retain evidence of indemnity cover from past periods indefinitely but we would expect a registrant to seek such evidence from the relevant employer or indemnity provider if requested. If the relevant indemnity provider had destroyed all such evidence under their records retention policy, before the request was made, the registrant would need to inform us accordingly.

5.18 Practising as a pharmacist or pharmacy technician is defined in the Pharmacy Order 2010 (article 3(2)) as being when ‘acting in the capacity of or purporting to be a pharmacist or pharmacy technician, that person undertakes any work or gives any advice in relation to the preparation, assembly, dispensing, sale, supply or use of medicines, the science of medicines, the practice of pharmacy or the provision of healthcare’.

5.19 It is each registrant’s responsibility to ensure that they have appropriate indemnity arrangements for all aspects of their practice. Given the range of pharmacy practice, we do not propose to offer guidance about what would be considered adequate scope and funding of indemnity cover. These are both aspects that registrants must consider. If they are unsure, they should check with their employer or indemnity provider.

5.20 As is the case under the existing requirements, being covered by an employer’s indemnity arrangements would not exempt a registrant from the requirement to have appropriate indemnity cover but it could mean that a registrant did not need to purchase additional cover. If a registrant’s employer had indemnity arrangements which provided appropriate cover in respect of liabilities that may be incurred in relation to that registrant’s practice, the registrant could simply provide details of their employer’s indemnity arrangements when requested.
5.21 An employed registrant, whether they work for a pharmacy owner or another employer, should consider whether any indemnity or insurance cover provided by their employer is sufficient or whether they need to make any additional arrangements to ensure appropriate cover for all aspects of their practice.

5.22 If a registrant was not practising at all for a period, for example because they were on a career break, maternity leave or between jobs, we would not require them to have indemnity cover during this period, although they might need run-off cover for any claims made relating to their previous time in practice. They would need to inform us within seven days of their indemnity cover ceasing and ensure that they had appropriate indemnity arrangements in place before beginning to practise again.

5.23 In relation to the impact of the changes on patient safety, this was considered in the impact assessment for the Health Care and Associated Professions (Indemnity Arrangements) Order 2014. This stated that some regulated health professionals were practising without indemnity or insurance cover, or with insufficient cover. The full benefits of the new arrangements would accrue to patients, who bear the cost of adverse events both in terms of cost and personal impact. They would have access to redress for any harm caused by the negligent activities of health care professionals. In addition, health care professionals who are covered by an appropriate indemnity arrangement, should they be involved in a negligent act that causes harm, would not be in danger of losing personal assets and potentially being made bankrupt.

5.24 The responses we received were broadly supportive, and we intend to go ahead with the proposals, with an adjustment to make clear that seven days would be the minimum period for responding to a request for information on indemnity arrangements – not a standard deadline. However, we recognise that there is a need for further guidance on indemnity arrangements. We will produce and publish guidance covering topics such as: employed and self-employed registrants, registrants in non-clinical practice, registrants practising overseas, registrants who are not currently practising and Good Samaritan acts, amongst others.

Entry in the register

What we proposed

Indemnity arrangements

5.25 We proposed amending rule 10 of the Registration Rules (entry in the register). An applicant for registration would be required to declare that they understand that:

- they cannot practise unless they have an indemnity arrangement in force which provides appropriate cover
- they must inform the registrar within seven days if they cease to have such an arrangement in force, and
- their entry in the register may be removed if such an arrangement is not in force
5.26 Applicants would complete a self-declaration that they have, or will have, an indemnity arrangement in force which provides appropriate cover (see current Registration Rule 10(3)(ga)). The exception to this would be where an applicant had been removed from the register previously for failing to comply with the indemnity requirements. Such applicants would be required to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising. An applicant who completed a self-declaration would also need to supply additional evidence if requested by the registrar, as described above.

Crown copyright and the front cover of a UK passport

5.27 In 2012, the Registration Rules were amended so that applicants for registration who supplied a certified copy of their UK passport as evidence of identity should not include the front page of their passport in the certified copy. This change was made as some applicants had found it difficult to obtain a certified copy of the whole of their passport because solicitors had declined to certify a copy including the front page, which bears the Royal Coat of Arms, on the ground that this was protected by Crown copyright.

5.28 The amendment was made but the Parliamentary Joint Committee on Statutory Instruments took the view that the rule should have stated that a copy of the passport with or without the front cover could be supplied. While understanding the reasoning behind the change, the Committee commented that the people authorised to certify copies of passports under the rules (notaries, solicitors or Commissioners for Oaths) could be assumed to have sufficient legal expertise to form their own views on the risks of including the front page. Their view was that, if a solicitor is content to certify a copy of the whole of a passport, that has no adverse effect on its value as evidence, which is what the need for certification is aimed at. We therefore proposed amending the rules so that a certified copy of a UK passport may or may not include the front cover.

Knowledge of English

5.29 An applicant for registration would also be required to provide evidence of having the necessary knowledge of English. The Council will be obliged to consult on and publish guidance about the evidence, information and documents that may be provided by an applicant for the purpose of satisfying the registrar that they have the necessary knowledge of English, and the process by which the registrar will determine whether he is satisfied that the person has this knowledge (see art. 23A of the Pharmacy Order, which was inserted by the Knowledge of English Order and came into force on 1 June 2016). The consultation on this guidance ran alongside the consultation on amendments to rules and the report can be found here [link].
What we heard

| Question 3 - Do you agree with the proposed changes on applications for entry in the register? |
|-----------------------------------------------|-----------------|----------------|
| Yes                                           | 36              | 49.3%          |
| No                                            | 10              | 13.7%          |
| Don’t know                                    | 10              | 13.7%          |
| Skipped question                              | 17              | 23.3%          |
| Total                                         | 73              | 100%           |

5.30 49.3% of respondents agreed with this proposal and 13.7% disagreed. 37% of respondents chose not to respond to this question or stated that they did not know.

5.31 One respondent indicated that not all registrants would need to have evidence of the necessary knowledge of English but did not specify why this was. Another suggested that all non-UK applicants should be required to achieve a score of at least 7 in each of the four areas of reading, writing, listening and speaking in the International English Language Testing System (IELTS) test.

Our response

5.32 We propose to go ahead with the amendments, subject to some minor amendments to the indemnity provisions made upon advice from Privy Council advisers. The amendments remove the express provisions requiring an applicant who has been removed from the register previously for failing to comply with the indemnity requirements to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising. Instead of an express provision, we will simply request that additional evidence from all such applicants under the Registrar’s power to do so. This avoids unnecessary duplication of information-gathering powers.

5.33 All registrants and applicants would need to be able to provide evidence of having the necessary knowledge of English on request. However, as set out in the draft guidance on evidence of language skills, this could be done in a number of ways, depending upon the background of the applicant or registrant. For example, our draft guidance proposed that UK qualified pharmacy professionals who have:

- successfully completed the relevant approved qualifications taught and examined in English under the supervision of a registered pharmacist in line with our registration criteria, and
- provided documentary evidence of these qualifications with their application for registration
would not normally be required to provide additional evidence to satisfy the registrar that they have the necessary knowledge of English.

5.34 The draft guidance also proposed that non-UK qualified applicants could provide different types of evidence to demonstrate their knowledge of English, including:
- evidence of having been awarded a primary pharmacy qualification taught and examined solely in English in a country where English is the first and native language;
- evidence of recent practice of at least two years in a country where English is the first and native language, or evidence of having achieved the required scores in the IELTS test.

5.35 We believe that having a range of acceptable types of evidence of knowledge of English, depending upon the background of the applicant or registrant, should allow a proportionate approach whilst providing the registrar with adequate assurance that the person has the necessary knowledge of English for the safe and effective practice of pharmacy.

Renewal of an entry in the register

What we proposed

5.36 We proposed that an applicant for renewal would have to specify whether they had, or would have, an indemnity arrangement in force providing appropriate cover. They would also have to declare that they understood that:
- they cannot practise unless they have an indemnity arrangement in force which provides appropriate cover
- they must inform the registrar within seven days if they cease to have such an arrangement in force, and
- their entry in the register may be removed if they do not have such an arrangement in force.

5.37 An applicant for renewal would have to specify whether they hold evidence demonstrating that they have the necessary knowledge of English.

5.38 Applicants would also need to supply additional evidence if reasonably required by the registrar for the purposes of verifying the information in or determining the application.

What we heard

| Question 4 - Do you agree with the proposed changes on applications for renewal of an entry in the register? | Yes | 31 | 42.5% |
42.5% of respondents agreed with this proposal and 15.1% disagreed. 42.5% of respondents chose not to respond to this question or stated that they did not know.

Some respondents raised points which have been addressed under question 2 above.

The responses were broadly supportive and we propose to go ahead with the amendments.

What we proposed

We proposed amending rule 12 of the Registration Rules, which relates to applications for an annotation to an entry in the register, denoting a specialisation. An applicant for an annotation would have to specify whether, if the annotation were to be made, they would have an indemnity arrangement in force providing appropriate cover.

If the applicant had been removed from the register previously for failing to comply with the indemnity requirements, they would have to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising.

What we heard

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<th>Yes</th>
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<td>7</td>
<td>9.6%</td>
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<td>25</td>
<td>34.2%</td>
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<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
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41.1% of respondents agreed with this proposal and 15.1% disagreed. 43.6% of respondents chose not to respond to this question or stated that they did not know.
5.45 An organisation commented that, while they agreed that a person who had been removed from the register previously for failing to comply with the indemnity requirements should be obliged to provide a copy of their insurance policy or other indemnity arrangement, they should also be subject to a ‘review period’, during which they would need to provide evidence of continued indemnity cover, until the registrar was satisfied that this additional monitoring was no longer necessary.

Our response

5.46 We propose to go ahead with the amendments, subject to the same minor amendment referred to at paragraph 5.32 above, made upon advice from Privy Council advisers. The amendment removes the express provision requiring an applicant who has been removed from the register previously for failing to comply with the indemnity requirements to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising. Instead of an express provision, we will simply request that additional evidence from all such applicants under the Registrar’s power to do so. This avoids unnecessary duplication of information-gathering powers.

5.47 As set out above, the rules would allow us to request evidence of indemnity arrangements from a registrant by issuing a notice. We might want to do this if, for example, concerns were raised that a person who had provided evidence of indemnity cover in order to be restored to the register had cancelled that cover shortly afterwards. It would seem preferable not to state a defined period of continued monitoring in such circumstances but to allow for a risk-based proportionate approach.

Renewal of an annotation made to an entry in the register

What we proposed

5.48 We proposed amending rule 13 of the Registration Rules, which relates to applications for renewal of an annotation to an entry in the register, denoting a specialisation. An applicant for renewal of an annotation would have to specify whether, if the annotation were renewed, they would have an indemnity arrangement in force providing appropriate cover. The registrar would be able to require the applicant to provide further information about their indemnity arrangements.

What we heard

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<th>Question 6 - Do you agree with the proposed changes on applications for renewal of an annotation to an entry in the register?</th>
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</tr>
<tr>
<td>No</td>
<td>10</td>
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<td>Total</td>
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5.49 39.7% of respondents agreed with this proposal and 13.7% disagreed. 46.6% of respondents chose not to respond to this question or stated that they did not know.

5.50 One respondent queried whether a registrant would be required to maintain an indemnity arrangement at a level which would cover practice relating to their annotation, such as independent prescribing, even if their current practice did not entail making use of that annotation.

Our response

5.51 We propose to go ahead with the amendments. An applicant for renewal of an annotation would have to specify whether, if the annotation were to be renewed, they would have an indemnity arrangement in force providing appropriate cover. Their indemnity cover would need to be appropriate for their practice: if they were not making use of their annotation for a period, they would need to ensure that their indemnity arrangements were appropriate for their current practice, and that they would have appropriate cover in place when they resumed making use of their annotation.

Restoration of an entry in the register

What we proposed

5.52 We proposed amending rule 16 of the Registration Rules, which relates to applications for restoration of an entry in the register i.e. an application to return to the register after an absence of up to a year. An applicant for restoration to the register would be required to declare that they understand that:

- they cannot practise unless they have an indemnity arrangement in force which provides appropriate cover
- they must inform the registrar within seven days if they cease to have such an arrangement in force, and
- their entry in the register may be removed if they do not have such an arrangement in force

5.53 Applicants for restoration would have to declare that they have, or will have, an indemnity arrangement in force which provides appropriate cover (see Registration Rule 16(3)(a)(i)(ab)). An exception to this would be where an applicant had been removed from the register previously for failing to comply with the indemnity
requirements. Such applicants would have to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising.

5.54 An applicant for restoration would have to specify whether they hold evidence demonstrating that they have the necessary knowledge of English.

What we heard

<table>
<thead>
<tr>
<th>Question 7 - Do you agree with the proposed changes on applications for restoration of an entry in the register?</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
</tr>
<tr>
<td>Skipped question</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
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</table>

5.55 45.2% of respondents agreed with this proposal and 8.2% disagreed. 46.6% of respondents chose not to respond to this question or stated that they did not know.

5.56 Some respondents raised points which have been addressed under questions 2 and 5 above.

Our response

5.57 The responses were broadly supportive and we propose to go ahead with the amendments, subject to the same minor amendment referred to at paragraph 5.32 and 5.45 above, made upon advice from Privy Council advisers. The amendment removes the express provision requiring an applicant who has been removed from the register previously for failing to comply with the indemnity requirements to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising. Instead of an express provision, we will simply request that additional evidence from all such applicants under the Registrar’s power to do so. This avoids unnecessary duplication of information-gathering powers.

Restoration of an annotation to an entry in the register

What we proposed

5.58 We proposed amending rule 17 of the Registration Rules, which relates to applications for restoration of an annotation to an entry in the register, denoting a specialisation. An applicant for restoration of an annotation would have to specify whether, if the
annotation were restored, they would have an indemnity arrangement in force providing appropriate cover.

5.59 Any applicant who had been removed from the register previously for failing to comply with the indemnity requirements would have to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising.

What we heard

| Question 8 - Do you agree with the proposed changes on applications for restoration of an annotation to an entry in the register? |
|-----------------|-----------------|-----------------|
| Yes             | 31              | 42.5%           |
| No              | 8               | 11.0%           |
| Don’t know      | 6               | 8.2%            |
| Skipped question| 28              | 38.4%           |
| Total           | 73              | 100%            |

5.60 42.5% of respondents agreed with this proposal and 11% disagreed. 46.6% of respondents chose not to respond to this question or stated that they did not know.

5.61 One respondent raised points which have been addressed under question 5 above.

Our response

5.62 The responses were broadly supportive and we propose to go ahead with the amendments, subject to the same minor amendment referred to at paragraph 5.32, 5.45 and 5.55 above, made upon advice from Privy Council advisers. The amendment removes the express provision requiring an applicant who has been removed from the register previously for failing to comply with the indemnity requirements to provide a copy of their insurance policy or other indemnity arrangement, together with a description of the activities they intend to undertake when practising. Instead of an express provision, we will simply request that additional evidence from all such applicants under the Registrar’s power to do so. This avoids unnecessary duplication of information-gathering powers.
6. Amendments to the GPhC Fitness to Practise and Disqualification etc Rules

6.1 This section covers amendments to The General Pharmaceutical Council (Fitness to Practise and Disqualification etc) Rules 2010 (S.I. 2010/1615). We proposed changes to implement the requirement for a registrant to have the knowledge of English necessary for safe and effective practice, as a condition of their registration, and to allow us to initiate fitness to practise proceedings in cases where a pharmacy professional’s knowledge of the English language may pose a serious risk to patient safety.

What we proposed

Interpretation

6.2 We proposed amending rule 2 of the Fitness to Practise and Disqualification Rules, which defines terms used in these rules. This would provide a definition of a ‘knowledge of English allegation’ (an allegation that a person’s fitness to practise is impaired by reason of not having the necessary knowledge of English for safe and effective practice).

Initial action in respect of allegations

6.3 We proposed amending rule 6 of the Fitness to Practise and Disqualification Rules (initial action in respect of allegations). Under this rule, the GPhC’s investigations of a knowledge of English allegation could include requiring the person concerned to undertake an examination or assessment of their knowledge of English and to provide evidence of the result within a specified period. If the registrar issued such a direction and the person concerned failed to comply with it, the registrar could treat that failure as an allegation of misconduct and refer it, with the knowledge of English allegation, directly to the Fitness to Practise Committee. Alternatively, the registrar may refer the misconduct allegation directly to the Fitness to Practise Committee without the knowledge of English allegation.

Notices of referral and documents to be supplied to persons concerned

6.4 We proposed amending rule 7 of the Fitness to Practise and Disqualification Rules (notices of referral and documents to be supplied to persons concerned). When a knowledge of English allegation was referred to the Investigating Committee, the registrar would be required to send the person concerned a copy of the Council’s guidance about the evidence, information and documents that may be provided for the purpose of satisfying the registrar that they have the necessary knowledge of English, and the process by which the registrar will determine whether he is satisfied that the person has this knowledge. The person would also be informed of the
committee’s power to require them to undertake an examination or assessment of their knowledge of English.

Applications for restoration

6.5 We proposed amending rule 8 of the Fitness to Practise and Disqualification Rules (applications for restoration). This amendment would mean that persons who had been removed from the register by the Fitness to Practise Committee and who then applied for restoration (article 57, Pharmacy Order) may need to provide evidence demonstrating that they have the necessary knowledge of English, as part of the evidence of their fitness to return to practice. This could include undertaking an examination or assessment of their knowledge of English and providing the result to the registrar.

Procedures of the Investigating Committee

6.6 We proposed amending rule 9 of the Fitness to Practise and Disqualification Rules (procedures of the Investigating Committee). Under this rule, the Investigating Committee, when considering a knowledge of English allegation, could direct the person concerned to undertake an examination or assessment of their knowledge of English and to provide evidence of the result to the registrar within a specified period. If the person concerned failed to comply with such a direction, the Investigating Committee could refer that failure to the Fitness to Practise Committee as an allegation of misconduct, with the knowledge of English allegation. Alternatively, the registrar may refer the misconduct allegation directly to the Fitness to Practise Committee without the knowledge of English allegation.

Action upon referral of an allegation

6.7 We proposed amending rule 13 of the Fitness to Practise and Disqualification Rules (action upon referral of an allegation). Under this rule, the Fitness to Practise Committee, when considering a knowledge of English allegation, could direct the person concerned to undertake an examination or assessment of their knowledge of English and to provide evidence of the result within a specified period.

Evidence

6.8 We proposed amending rule 24 of the Fitness to Practise and Disqualification Rules (evidence). The amendment would allow the Fitness to Practise Committee, when determining whether a person’s fitness to practise is impaired by not having the necessary knowledge of English, to take into account any failure by that person to undertake an examination or assessment of their knowledge of English and to provide evidence of the result of that examination or assessment.

What we heard
Question 9 - Do you agree with the proposed changes to fitness to practise proceedings in cases where it is alleged that a pharmacy professional does not have the knowledge of English necessary for safe and effective practice?

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<tbody>
<tr>
<td>Yes</td>
<td>37</td>
<td>50.7%</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>Don't know</td>
<td>4</td>
<td>5.5%</td>
</tr>
<tr>
<td>Skipped question</td>
<td>29</td>
<td>39.7%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
</tr>
</tbody>
</table>

6.9 50.7% of respondents agreed with this proposal and 4.1% disagreed. 45.2% of respondents chose not to respond to this question or stated that they did not know.

6.10 A pharmacy organisation commented that knowledge of English was a prerequisite for registration, and so a person must provide evidence of an examination or assessment. Another said that it was important that these changes were considered as necessary, as patient safety was paramount.

Our response

6.11 The responses were broadly supportive and we propose to go ahead with the amendments.

7. Equality, diversity and inclusion


No further issues relating to equality, diversity and inclusion were raised in consultation responses.
8. Other comments

What we asked

8.1 We asked for any further comments about the draft GPhC (Amendment of Miscellaneous Provisions) Rules.

What we heard

Question 10 - Do you have any other comments you want to make?

8.2 Some of the responses received to this question have been addressed elsewhere in this report.

8.3 One organisation drew our attention to comments it had made to the Department of Health in response to its consultation on the Health Care and Associated Professions (Indemnity Arrangements) Order. They supported the rationale for regulators to be able to remove registrants from the register, or take fitness to practise action against them, in the event of non-compliance with the indemnity requirements. They also said that it would be important to ensure that decisions about whether to remove someone from the register administratively or to use the fitness to practise route were made in the interests of public protection. They believed there was a potential for bias towards administrative removal, as the less onerous option, and pointed out that the Professional Standards Authority did not have power to review these decisions to ensure they were in the public interest. On the other hand, they noted that decisions must be fair and equitable to the registrant, given the potential impact of fitness to practise proceedings on them; and expressed a wish to see some consistency both within each regulator and across regulators about cases which result in fitness to practise proceedings. Other potential challenges noted were how to deal with non-compliance if a case was referred to a fitness to practise panel but no impairment was found, or how to avoid situations where fitness to practise action could not be taken because the person had been removed from the register administratively for non-compliance with the indemnity requirements.

8.4 One respondent thought that the proposals would help to provide a stronger workforce, embodying professionalism. An organisation commented that it supported the proposals as they would enhance patient care and safety.

Our response

8.5 If a registrant did not have appropriate indemnity cover or failed to comply with the rules, they could be removed from the register administratively. Alternatively, the failure could be treated as misconduct and considered for referral as a fitness to practise case.
8.6 Administrative removal would be a proportionate approach which avoids the lengthy, costly alternative of fitness to practise procedures, the costs of which are borne by registrants as a whole. The person concerned would also have a right of appeal to the Appeals Committee. That is not to say that fitness to practise action might not be appropriate in some circumstances, for example if a registrant had had a number of fitness to practise issues and then failed to comply with the indemnity requirements, it might be thought appropriate to refer the matter to the Fitness to Practise Committee so that they could consider whether the person concerned should be removed from the register and then be unable to apply for restoration within five years. The Fitness to Practise Committee could also exercise its power under article 56 of the Pharmacy Order to make an interim suspension order if necessary.

8.7 If a person was removed from the register administratively for failure to comply with the indemnity requirements and a fitness to practise concern was then raised, that would need to be recorded for consideration in the event that the person applied to return to the register.

8.8 The procedure for administrative removal from the register for non-compliance with the indemnity requirements does not appear in the rules themselves, as we do not have powers to make such rules. We nevertheless plan to use internal guidance and a standard procedure for any such removals, to help ensure a consistent approach.

8.9 We are grateful for the feedback we have received. We will continue to keep the content of our rules under review.
Appendix 1: Respondents to the consultation

We received 73 responses to the consultation, 33 from individuals and 9 from organisations. Below is a list of organisations that responded to the consultation (one organisation did not identify itself).

Responses from organisations
Aneurin Bevan Community Health Council
Association of Pharmacy Technicians UK
Community Pharmacy Wales
Guild of Healthcare Pharmacists
Pharmacists’ Defence Association
PharmacyVoice
Professional Standards Authority
Rowlands Pharmacy

Made - - - - ***
Laid before Parliament ***
Laid before the Scottish Parliament ***
Coming into force - - ***

At the Council Chamber, Whitehall, the *** day of ***

By the Lords of Her Majesty’s Most Honourable Privy Council

The General Pharmaceutical Council\(^{(a)}\) has made the General Pharmaceutical Council (Amendment of Miscellaneous Provisions) Rules 2016 which are set out in the Schedule to this Order, in exercise of the powers conferred by articles 23(1), 27(1), 32(4), (5) and (6), 37(3), 52(1) and (2), 55A(1) and (3), 57(3), 61(1) and (3)(h) and 66(1) of, and paragraph 5(1)(a) of Schedule 1 to, the Pharmacy Order 2010\(^{(b)}\).

In accordance with article 66(3) of that Order, the General Pharmaceutical Council has, in relation to rules under Parts 4, 6 and 7 of that Order, consulted such persons and organisations as it considered appropriate including the persons and organisations listed in sub-paragraphs (a) to (h) of article 66(3) of that Order\(^{(c)}\).

By virtue of article 66(4) of that Order, such rules cannot come into force until approved by order of the Privy Council.

Citation and commencement

1. This Order may be cited as the General Pharmaceutical Council (Amendment of Miscellaneous Provisions) Rules Order of Council 2016 and comes into force on [date].

\(^{(a)}\) The Council was established by article 4 of the Pharmacy Order 2010 (S.I. 2010/231) (“the Pharmacy Order”).

\(^{(b)}\) Article 32 was substituted by S.I. 2014/1887. Article 55A was inserted, and article 61(3)(h) was amended, by S.I. 2015/806. See article 3(1) of the Pharmacy Order for the definition of “prescribed” which is relevant to the powers being exercised in the making of the Rules set out in the Schedule to this Order.

\(^{(c)}\) Article 66(3)(a) was amended by S.I. 2013/235.
Council Approval

2. Their Lordships, having taken the Rules contained in the Schedule into consideration, are pleased to and do approve them.

Signatory text

Richard Tilbrook
Clerk of the Privy Council

SCHEDULE

The General Pharmaceutical Council (Amendment of Miscellaneous Provisions) Rules 2016

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Amendments to the General Pharmaceutical Council (Registration) Rules 2010

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7. Amendment of rule 13 of the Registration Rules
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9. Amendment of rule 17 of the Registration Rules

PART 4
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10. Amendment of rule 2 of the Fitness to Practise Rules
11. Amendment of rule 6 of the Fitness to Practise Rules
12. Amendment of rule 7 of the Fitness to Practise Rules
13. Amendment of rule 8 of the Fitness to Practise Rules
14. Amendment of rule 9 of the Fitness to Practise Rules
15. Amendment of rule 13 of the Fitness to Practise Rules
16. Amendment of rule 24 of the Fitness to Practise Rules
The General Pharmaceutical Council makes these Rules in exercise of the powers conferred by articles 23(1), 27(1), 32(4), (5) and (6), 37(3), 52(1) and (2), 55A(1) and (3), 57(3), 61(1) and (3)(h) and 66(1) of, and paragraph 5(1)(a) of Schedule 1 to, the Pharmacy Order 2010.

In accordance with article 66(3) of that Order, the General Pharmaceutical Council has, in relation to rules under Parts 4, 6 and 7 of that Order, consulted such persons and organisations as it considered appropriate including the persons and organisations listed in sub-paragraphs (a) to (h) of article 66(3) of that Order.

PART 1
General

Citation, commencement and interpretation

1.—(1) These Rules may be cited as the General Pharmaceutical Council (Amendment of Miscellaneous Provisions) Rules 2016 and come into force on [date].

(2) In these Rules—

“the Fitness to Practise Rules” means the General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010(a);

“the Registration Rules” means the General Pharmaceutical Council (Registration) Rules 2010(b);

“the Statutory Committees and their Advisers Rules” means the General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010(c).

PART 2
Amendment to the General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010

Amendment of rule 18B of the Statutory Committees and their Advisers Rules

2. In rule 18B of the Statutory Committees and their Advisers Rules (composition of Appeals Committee: further provision)(d), in paragraph (2)—

(a) omit “and” at the end of sub-paragraph (b); and

(b) after sub-paragraph (c) insert

“; and

(d) any member who has sat in a formation of the Fitness to Practise Committee that has given advice on, or made findings of fact in relation to, a particular matter does not sit in a formation of the Appeals Committee that hears an appeal in proceedings connected with that matter.”.

(a) Scheduled to S.I. 2010/1615.
(b) Scheduled to S.I. 2010/1617.
(c) Scheduled to S.I. 2010/1616.
(d) Rule 18B was inserted by S.I. 2012/3171.
PART 3
Amendments to the General Pharmaceutical Council (Registration) Rules 2010

New rule 8A of the Registration Rules

3. After rule 8 of the Registration Rules insert—

“Duty to provide information about indemnity arrangements: registrants

8A.—(1) A registrant entered in Part 1 or, as the case may be, Part 2 of the Register must provide such information as the Registrar may require by notice in writing for the purposes of determining whether, at any time, there is in force an indemnity arrangement which provides appropriate cover in relation to the registrant or to registrants of a particular description.

(2) Information which may be required by a notice under paragraph (1) includes, in particular—

(a) the name and address of any employer of the registrant;
(b) a description of the activities within the scope of the registrant’s practice as a pharmacist or, as the case may be, a pharmacy technician;
(c) details of any insurance policy or other arrangement which provides appropriate cover in relation to the registrant which—

(i) was in force in respect of any period specified in the notice,
(ii) is in force when the notice is issued, or
(iii) will be in force by the time the registrant begins to practise as a pharmacist or, as the case may be, a pharmacy technician; and
(d) the name of any person or persons providing any such insurance policy or other arrangement.

(3) The registrant must provide the information required by a notice under paragraph (1) within such period (not being less than 7 days from the date on which the Registrar issues the notice) as may be specified in the notice.

(4) A notice under paragraph (1) must inform the registrant that, if the required information is not provided in accordance with the requirements of paragraph (3)—

(a) the Registrar may, under article 32(8) of the Order, refuse to renew the registrant’s entry in Part 1 or 2 of the Register (as the case may be);
(b) the Registrar may, under article 32(9)(a) of the Order, remove the registrant’s name from that part of the Register; or
(c) the registrant’s failure to comply with those requirements may, by virtue of article 32(9)(b) of the Order, be treated as misconduct for the purposes of article 51(1)(a) of the Order.

(5) A registrant entered in Part 1 or, as the case may be, Part 2 of the Register must in the event that there is in force no indemnity arrangement which provides appropriate cover in relation to the registrant, inform the Registrar in writing of that fact within 7 days of the cessation of appropriate cover under any such arrangement.”

(a) “Indemnity arrangement” and “appropriate cover” are defined in article 32(2) and (3) of the Pharmacy Order 2010.
Amendment of rule 10 of the Registration Rules

4.—(1) Rule 10 of the Registration Rules (entry in the Register) is amended as follows.

(2) In paragraph (2)(a)(iii)—

(a) omit “and” at the end of sub-paragraph (bb); and

(b) after sub-paragraph (cc) insert—

“(dd) understands that, upon entry in the Register, the applicant cannot practise as a pharmacist or, as the case may be, a pharmacy technician unless there is in force an indemnity arrangement which provides appropriate cover in relation to the applicant, and

(ee) agrees, in the event that there is in force in relation to the applicant no such arrangement, to inform the Registrar in writing of that fact within 7 days of the cessation of appropriate cover under any such arrangement and understands that the applicant’s entry may be removed from the Register.”.

(3) In paragraph (3)—

(a) in each of sub-paragraphs (a)(i), (c)(i), (d)(i) and (f)(ii), for “which meets the conditions set out in paragraph (3A)” substitute “to which paragraph (3A) applies”;

(b) omit “and” at the end of sub-paragraph (j); and

(c) after sub-paragraph (k) insert

“; and

(l) evidence, information or documents demonstrating that the applicant has the necessary knowledge of English for the purpose of complying with article 20(1)(a)(ia) of the Order.”

(4) For paragraph (3A) substitute—

“(3A) This paragraph applies to a copy of—

(a) a United Kingdom passport within the meaning of the Immigration Act 1971 (whether or not the front cover of the passport is included in the copy); or

(b) any other passport,

which is certified by a notary, solicitor or Commissioner for Oaths as a true copy of an original passport referred to in sub-paragraph (a) or (b).”

(5) In paragraph (5)—

(a) for “The additional matters referred to in paragraph (4) are—” substitute “The following may, in particular, be required under paragraph (4)—”;

(b) omit “and” at the end of sub-paragraph (f); and

(c) at the end of sub-paragraph (g) insert

“; and

(h) in the case of an applicant who provided the evidence referred to in paragraph (3)(ga) by way of a self-declaration—

---

(a) Rule 10(2)(a)(ii)(cc) and (3)(ga) were inserted by S.I. 2014/1887. Rule 10(3) and (5)(b) were amended, and rule 10(3A) and (3B) were inserted, by S.I. 2012/3171. Rule 10(5)(a), (e) and (f) and (12) were amended, and rule 10(5)(g) was inserted, by S.I. 2010/2660.

(b) A definition of “the necessary knowledge of English” was inserted in article 3(1) of the Pharmacy Order 2010 by S.I. 2015/806. In determining whether a person has the necessary knowledge of English, the Registrar is required to have regard to guidance published by the Council under article 23A of the Pharmacy Order 2010. Article 23A was inserted by S.I. 2015/806.

(c) The definition of “United Kingdom Passport” in section 33 of the Immigration Act 1971 (c.77) was inserted by paragraph 7(a)(ii) of Schedule 4 to the British Nationality Act 1981 (c. 61) and amended by section 1(1)(b) of the British Overseas Territories Act 2002 (c. 8).
(i) a copy of any insurance policy or other arrangement indemnifying the applicant which is in force, or the details of any such policy or arrangement which will be in force, in relation to the applicant, and

(ii) a description of the activities which the applicant intends to undertake when practising as a pharmacist or, as the case may be, a pharmacy technician.”.

Amendment of rule 11 of the Registration Rules

5.—(1) Rule 11 of the Registration Rules (renewal of an entry in the Register) is amended as follows.

(2) In paragraph (4)(a)—

(a) in paragraph (iia), for “provide evidence that” substitute “specify whether”;

(b) after that paragraph insert—

“(iib) declare that the registrant understands that the registrant cannot practise as a pharmacist or, as the case may be, a pharmacy technician unless there is in force an indemnity arrangement which provides appropriate cover in relation to the registrant,

(iic) declare that the registrant agrees, in the event that there is in force in relation to the registrant no such arrangement, to inform the Registrar in writing of that fact within 7 days of the cessation of appropriate cover under any such arrangement and understands that the registrant’s entry may be removed from the Register,”; and

(c) omit “and” at the end of paragraph (iv); and

(d) after paragraph (v) insert—

“(vi) specify whether the registrant holds evidence, information or documents demonstrating that the registrant has the necessary knowledge of English for the purpose of complying with article 20(2)(a)(iia) of the Order;”.

(3) After paragraph (5) insert—

“(5A) The registrant must also provide such additional documents, information or evidence as the Registrar may reasonably require for the purposes of verifying the information in, or determining, the application.”.

(4) In paragraph (6)(b), after “as mentioned in the application form” insert “or subsequently required by the Registrar”.

Amendment of rule 12 of the Registration Rules

6. In rule 12 of the Registration Rules (annotations made to an entry in the Register), in paragraph (3)(a)—

(a) omit “and” at the end of paragraph (v); and

(b) after paragraph (v) insert—

“(va) specify whether, if an annotation in respect of a specialisation were to be made to the applicant’s entry, there would be in force an indemnity arrangement which provides appropriate cover in relation to the applicant, and”.

(a) Rule 11(4)(a)(iia) was inserted by S.I. 2014/1887.
Amendment of rule 13 of the Registration Rules

7.—(1) Rule 13 of the Registration Rules (renewal of an annotation made to an entry in the Register) is amended as follows.

(2) In paragraph (4)(b), after paragraph (iii) insert—

“(iii) specify whether, if an annotation in respect of a specialisation were to be renewed, there would be in force an indemnity arrangement which provides appropriate cover in relation to the applicant,”.

(3) In paragraph (6)(b), after “as mentioned in the application form” insert “or subsequently required by the Registrar”.

Amendment of rule 16 of the Registration Rules

8.—(1) Rule 16 of the Registration Rules (restoration of an entry in the Register) is amended as follows.

(2) In paragraph (3)(a)—

(a) omit “and” at the end of paragraph (ii)(bb);
(b) after paragraph (ii)(cc) insert—

“(dd) that A understands that, upon A’s entry being restored to the Register, A cannot practise as a pharmacist or, as the case may be, a pharmacy technician unless there is in force an indemnity arrangement which provides appropriate cover in relation to A, and

(ee) that A agrees, in the event that there is in force in relation to A no such arrangement, to inform the Registrar in writing of that fact within 7 days of the cessation of appropriate cover under any such arrangement and understands that A’s entry may be removed from the Register,”;

(c) in paragraph (iii)—

(i) in each of sub-paragraphs (aa) and (bb), for “the registrant” substitute “A”,
(ii) in sub-paragraph (bb), for “the registrant’s” substitute “A’s”, and
(iii) omit “and” at the end of sub-paragraph (bb); and

(d) after paragraph (iii) insert—

“(iiia) specify whether A holds evidence, information or documents demonstrating that A has the necessary knowledge of English for the purpose of complying with article 20(1)(a)(iia) of the Order, and”.

Amendment of rule 17 of the Registration Rules

9. In rule 17 of the Registration Rules (restoration of an annotation made to an entry in the Register), in paragraph (3)(a)(i), after sub-paragraph (aa) insert—

“(ab) whether, if an annotation in respect of a specialisation were to be restored to the applicant’s entry, there would be in force an indemnity arrangement which provides appropriate cover in relation to the applicant.”.
PART 4

Amendments to the General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010

Amendment of rule 2 of the Fitness to Practise Rules

10. In rule 2 of the Fitness to Practise Rules (interpretation), in paragraph (1), after the definition of “interim order hearing” insert—

“knowledge of English allegation” means a complaint to, or concern of, the Council which gives rise to, or may give rise to, an inquiry that a person’s fitness to practise is impaired by reason of article 51(1)(ca) of the Order;”(a).

Amendment of rule 6 of the Fitness to Practise Rules

11.—(1) Rule 6 of the Fitness to Practise Rules (initial action in respect of allegations) is amended as follows.

(2) In paragraph (4)—

(a) omit “or” at the end of sub-paragraph (c); and
(b) after sub-paragraph (d) insert

“; or

(e) in relation to a knowledge of English allegation, directing the person concerned—

(i) to undertake an examination or other assessment of that person’s knowledge of English, and

(ii) to provide to the Registrar evidence of the result of that examination or assessment.”.

(3) After paragraph (4) insert—

“(4A) Any direction under paragraph (4)(e) is to be given by the Registrar by a notice in writing which—

(a) specifies the name of the examination or assessment of knowledge of English which the person concerned is required to undertake;

(b) states that the evidence referred to in paragraph (4)(e)(ii) is to be provided in the form of a certificate or other document which—

(i) states the result of the examination or assessment, and

(ii) is signed by an officer of the body which provides the examination or assessment; and

(c) specifies the date by which such evidence is to be provided, and the person concerned must comply with the direction by the date specified in the notice or, if the Registrar agrees by a further notice in writing to extend that period, within the extended period specified in that notice.

(4B) The Registrar may disclose to any of the statutory committees or any employee of the Council any evidence provided pursuant to a direction given under paragraph (4)(e).”.

(4) After paragraph (7A)(b) insert—

“(7B) Where the Registrar has given a direction under paragraph (4)(e) and the person concerned has failed to comply with it, the Registrar may—
(a) refer the knowledge of English allegation to the Committee instead of to the Investigating Committee and treat the failure to comply with the direction as a separate allegation of misconduct and refer that allegation to the Committee; or

(b) determine not to refer the knowledge of English allegation to the Committee but treat the failure to comply with the direction as a separate allegation of misconduct and refer that allegation to the Committee.”.

(5) In paragraph (8), for “paragraph (5), (6), (7) or (7A)” substitute “any of paragraphs (5) to (7B)”.

Amendment of rule 7 of the Fitness to Practise Rules

12.—(1) Rule 7 of the Fitness to Practise Rules (notices of referral and documents to be supplied to persons concerned) is amended as follows.

(2) In paragraph (1)(b)—

(a) omit “and” at the end of paragraph (i); and

(b) after paragraph (ii) insert

“; and

(iii) where the person is the subject of a knowledge of English allegation, a copy of the guidance published by the Council under article 23A of the Order.”.

(3) In paragraph (2), after sub-paragraph (d)(ii) insert—

“(iii) in relation to a knowledge of English allegation, to direct the person concerned to undertake an examination or other assessment of that person’s knowledge of English.”.

Amendment of rule 8 of the Fitness to Practise Rules

13.—(1) Rule 8 of the Fitness to Practise Rules (applications for restoration) is amended as follows.

(2) In paragraph (3)(b), after paragraph (i) insert—

“(ia) evidence, information or documents demonstrating that the person has the necessary knowledge of English for the purpose of complying with article 20(1)(a)(iiia) of the Order,”.

(3) After paragraph (4) insert—

“(4A) If, having considered any evidence, information or documents provided under paragraph (3)(b)(ia), the Registrar is not satisfied that the person applying for restoration to Part 1 or, as the case may be, Part 2 of the Register has the necessary knowledge of English, the Registrar may direct the person—

(a) to undertake an examination or other assessment of that person’s knowledge of English; and

(b) to provide to the Registrar evidence of the result of that examination or assessment.

(4B) Any direction under paragraph (4A) is to be given by the Registrar by a notice in writing which—

(a) specifies the name of the examination or assessment of knowledge of English which the person is required to undertake;

(b) states that the evidence referred to in paragraph (4A)(b) is to be provided in the form of a certificate or other document which—

(i) states the result of the examination or assessment, and

(a) Article 23A was inserted by S.I. 2015/806.
(ii) is signed by an officer of the body which provides the examination or assessment; and

c) specifies the date by which such evidence is to be provided,

and the person must comply with the direction by the date specified in the notice or, if the Registrar agrees by a further notice in writing to extend that period, within the extended period specified in that notice.

(4C) The Registrar may disclose to any of the statutory committees or any employee of the Council any evidence provided pursuant to a direction under paragraph (4A).”.

Amendment of rule 9 of the Fitness to Practise Rules

14. In rule 9 of the Fitness to Practise Rules (procedures of the Investigating Committee), after paragraph (5) insert—

“(5A) In relation to a knowledge of English allegation, the Investigating Committee may—

(a) give a direction in accordance with paragraph (5B) which requires the person concerned—

(i) to undertake an examination or other assessment of that person’s knowledge of English, and

(ii) to provide to the Registrar evidence of the result of that examination or assessment; and

(b) where it receives information that the person concerned has failed to comply with any such direction—

(i) refer the knowledge of English allegation to the Committee and treat the failure to comply with the direction as a separate allegation of misconduct and refer that allegation to the Committee, or

(ii) determine not to refer the knowledge of English allegation to the Committee but treat the failure to comply with the direction as a separate allegation of misconduct and refer that allegation to the Committee.

(5B) Any direction under paragraph (5A)(a) is to be given by the Investigating Committee by a notice in writing which—

(a) specifies the name of the examination or assessment of knowledge of English which the person concerned is required to undertake;

(b) states that the evidence referred to in paragraph (5A)(a)(ii) is to be provided in the form of a certificate or other document which—

(i) states the result of the examination or assessment, and

(ii) is signed by an officer of the body which provides the examination or assessment; and

(c) specifies the date by which such evidence is to be provided,

and the person concerned must comply with the direction by the date specified in the notice or, if the Registrar agrees by a further notice in writing to extend that period, within the extended period specified in that notice.

(5C) The Investigating Committee may disclose to any other statutory committee or any employee of the Council any evidence provided pursuant to a direction given under paragraph (5A)(a).”.

Amendment of rule 13 of the Fitness to Practise Rules

15.—(1) Rule 13 of the Fitness to Practise Rules (action upon referral of an allegation) is amended as follows.

(2) In paragraph (1), after sub-paragraph (a) insert—
“(ab) in the case of a knowledge of English allegation, the chair may give a direction requiring the person concerned—

(i) to undertake an examination or other assessment of that person’s knowledge of English, and

(ii) to provide to the Registrar evidence of the result of that examination or assessment;”.

(3) After paragraph (1) insert—

“(1A) Any direction under paragraph (1)(ab) is to be given by the chair by a notice in writing which—

(a) specifies the name of the examination or assessment of knowledge of English which the person concerned is required to undertake;

(b) states that the evidence referred to in paragraph (1)(ab)(ii) is to be provided in the form of a certificate or other document which—

(i) states the result of the examination or assessment, and

(ii) is signed by an officer of the body which provides the examination or assessment; and

(c) specifies the date by which such evidence is to be provided,

and the person concerned must comply with the direction by the date specified in the notice or, if the Registrar agrees by a further notice in writing to extend that period, within the extended period specified in that notice.

(1B) The Committee may disclose to any other statutory committee or any employee of the Council any evidence provided pursuant to a direction given under paragraph (1)(ab).”.

Amendment of rule 24 of the Fitness to Practise Rules

16. In rule 24 of the Fitness to Practise Rules (evidence), after paragraph (11) insert—

“(11A) In determining whether a person’s fitness to practise is impaired by reason of not having the necessary knowledge of English, the Committee may take into account, amongst other matters—

(a) a failure by the person concerned to comply with a direction given under these Rules to undertake an examination or other assessment of that person’s knowledge of English; and

(b) a failure by the person concerned to provide to the Registrar evidence of the result of any such examination or assessment.”.

Given Under the official seal of the General Pharmaceutical Council this day of

Nigel Clarke
Chair
Duncan Rudkin
Chief Executive
EXPLANATORY NOTE
(This note is not part of the Order)

This Order approves the General Pharmaceutical Council (Amendment of Miscellaneous Provisions) Rules 2016 (“the Rules”). The Rules were made by the General Pharmaceutical Council (“the Council”) under the Pharmacy Order 2010 (S.I. 2010/231) (“the Pharmacy Order”).

Part 2 of the Rules contains an amendment to the General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010 (S.I. 2010/1616). The amendment in rule 2 prevents any person who has sat as a member of the Council’s Fitness to Practise Committee when considering any matter from also acting as a member of the Appeals Committee in proceedings connected with the same matter.

Part 3 of the Rules amends provisions of the General Pharmaceutical Council (Registration) Rules 2010 (S.I. 2010/1617) (“the Registration Rules”). Rule 3 sets out circumstances in which persons who are entered in Part 1 or Part 2 of the Register that is established and maintained under article 19 of the Pharmacy Order are required to provide to the Registrar information about any indemnity arrangement which relates to the person’s practice as a registered pharmacist or a registered pharmacy technician. In rule 4, paragraphs (2) and (5) impose requirements relating to the indemnity cover which an applicant for entry in Part 1 or 2 of the Register must have in place in order to practise as a pharmacist or pharmacy technician. Paragraphs (3)(b) and (c) of that rule require such applicants to demonstrate that they have the knowledge of English necessary to practise as a pharmacist or pharmacy technician. The remaining provisions of rule 4 provide that a copy of a UK passport, which is required when making an application for registration, does not need to include the front cover. Rule 5 requires registrants who are making an application to renew their registration to meet specified requirements relating to indemnity cover and knowledge of English. Rule 6 imposes requirements about indemnity cover in relation to registrants applying to have an annotation in respect of a specialisation made to their entry in Part 1 or 2 of the Register and rule 7 imposes requirements about indemnity cover in relation to registrants making an application to renew any such annotation. Rule 8 imposes requirements about indemnity cover and knowledge of English in relation to applicants for the restoration of an entry in Part 1 or 2 of the Register. Rule 9 imposes requirements about indemnity cover in relation to applicants for the restoration of an annotation to such an entry.

Part 4 of the Rules makes a number of amendments to the General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010 (S.I. 2010/1615). Rule 10 defines what is meant by “a knowledge of English allegation”. Rule 11 enables the Registrar to give a direction requiring a person subject to such an allegation to undertake an examination or other assessment as to their knowledge of English and to provide the Registrar with the results obtained. Rule 11 also enables any failure to comply with such a direction to be referred directly to the Council’s Fitness to Practise Committee instead of to its Investigating Committee. Rule 12 makes provision as to information that must be provided to any person who is subject to a knowledge of English allegation which has been referred to the Investigating Committee. In the case of a person applying for restoration of an entry which was removed from the Register by a direction given by the Fitness to Practise Committee, rule 13 provides that the evidence which the person must provide to demonstrate that they are fit to return to practice may include evidence that the person has the knowledge of English necessary to practise as a pharmacist or pharmacy technician. It also enables the Registrar to require any such applicant to undertake an examination or other assessment as to their knowledge of English and to provide the Registrar with the results obtained. Rule 14 enables the Investigating Committee to require a person subject to a knowledge of English allegation to undertake an examination or other assessment as to their knowledge of English and to provide the Registrar with the results obtained and rule 15 confers equivalent powers on the Fitness to Practise Committee. Rule 16 enables the Fitness to Practise Committee to take account of a person’s failure to comply with a direction requiring the person to undertake a knowledge of English assessment when that Committee is determining whether a person’s fitness to practise is impaired.
Draft guidance on evidence of English language skills and consultation report

Purpose
To provide Council with a final draft of guidance on evidence of English language skills and a draft report of the consultation on this guidance.

Recommendations
Council is asked to agree the:

(i) draft report of the consultation on guidance on evidence of English language skills (Appendix 1)

(ii) draft guidance on evidence of English language skills (Appendix 2)

1. Introduction

1.1 The Health Care and Associated Professions (Knowledge of English) Order (SI 2015/806) was made in March 2015. It amended the Pharmacy Order to strengthen the GPhC’s powers to introduce fair and proportionate language controls and to require EU applicants to provide evidence of their knowledge of the English language, following recognition of their professional qualification but before registration.

1.2 The Knowledge of English Order requires the GPhC to consult on and publish guidance setting out the evidence, information or documents that an applicant may provide to demonstrate that they have the necessary knowledge of the English language for safe and effective practice as a pharmacist or a pharmacy technician.

1.3 Council agreed the content of the draft guidance on evidence of English language skills for consultation in September 2015. The consultation ran for 12 weeks in parallel with the consultation on draft amendments to rules and closed on 17 December 2015. The responses to the consultation on guidance on evidence of English language skills are summarised in the draft report at Appendix 1.
1.4 The responses received were generally supportive and it is proposed that Council agrees the draft guidance on evidence of English language skills at Appendix 2.

2. **Equality and diversity implications**

2.1 An equality analysis of the draft guidance was published on the GPhC website during the consultation.

2.2 The main considerations were around race and disability. In summary, the Knowledge of English Order makes a lack of competence in the English language a separate ground of impairment of fitness to practise. This could have some impact on the representation in fitness to practise processes of foreign registrants. However, these provisions will apply to all applicants, including those from the UK. The policy is not therefore directly discriminatory against nationals of particular countries or people of particular ethnicities.

2.3 There could also potentially be some impact on the representation in fitness to practise processes of people with speech and language difficulties. The statutory committees, when determining an individual’s fitness to practise, take into account a number of factors, including the impact of any disability or health condition. That would not change upon the introduction of this policy. In addition providers of English language assessments would need to take into account any disability or health condition that the person might have when conducting an assessment and would need to consider any request for a reasonable adjustment to the process. The International English Language Testing System meets this requirement through its application form.

2.4 No further equality and diversity implications have been identified arising from the proposed amendments. Full details can be seen in the equality analysis.

3. **Communications implications**

3.1 The consultation report and the final version of the guidance will be published on the GPhC’s website. Once the rules come into effect, the new requirements and guidance relating to knowledge of English will be promoted to key audiences including registrants, students and trainees, patients and the public through national, local and pharmacy media, social media, a targeted email campaign, Regulate and other appropriate communications channels. Through these communications we aim to make registrants and potential future applicants aware of the new requirements and to give assurance to patients and the public that pharmacy professionals will have to demonstrate that they have the necessary knowledge of English to practise safely and effectively.
4. Resource implications

4.1 There are no significant resource implications involved. Internationally qualified pharmacist applicants are already required to provide evidence of having successfully passed the IELTS test before registration, and UK qualified applicants would not normally be required to do so. There could potentially be some impact on processing applications from European qualified pharmacy professionals. However this should be minimal as our application processes are already aligned with the legislative structure of a recognition of qualification stage followed by a separate registration stage. Evidence of having the necessary knowledge of English language would be reviewed at the registration stage of the process.

4.2 However for registrant renewals, there will be a need for IT development of CRM, the renewals section of myGPhC and to update our renewals telephone service (or consider removing at this stage) to capture the new declarations which will need to be made and imported into CRM.

4.3 Additionally as explained above we would not expect to see a significant increase in concerns about registrants following the implementation of this guidance.

5. Risk implications

5.1 If the guidance was not agreed we would not be able to fully implement the statutory changes concerning requirements for applicants and registrants to have the knowledge of English necessary for safe and effective practice as a condition of their registration with us.

Recommendations

Council is asked to agree the:

(i) draft report of the consultation on guidance on evidence of English language skills (Appendix 1)

(ii) draft guidance on evidence of English language skills (Appendix 2)

Martha Pawluczyk, Policy Manager (International)
General Pharmaceutical Council
martha.pawluczyk@pharmacyregulation.org
020 3713 7991
26 August 2016
Consultation report: draft guidance on evidence of English language skills

April 2016
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2. Summary
3. Background
4. Who we heard from
5. What we heard and our response

Appendix 1: Profile of individual respondents
Appendix 2: Organisations that responded to the consultation
Consultation report on draft guidance on evidence of English language skills

1. About this report

1.1 This report provides a summary of the responses to the consultation on draft guidance on evidence of English language skills held between 24 September and 17 December 2015.

1.2 The report provides background to the consultation, a breakdown of the responses to our proposals and a commentary on the responses. An analysis of respondent data can be found in Appendix 1, while Appendix 2 provides a list of the organisations that responded to the consultation.

2. Summary

2.1 The General Pharmaceutical Council (GPhC) is the independent regulator for pharmacists, pharmacy technicians and registered pharmacies in Great Britain. The main pieces of legislation governing the GPhC are the Pharmacy Order 2010 and the Medicines Act 1968.

2.2 The Health Care and Associated Professions (Knowledge of English) Order (SI 2015/806) (The Knowledge of English Order) improves public protection by amending the Pharmacy Order to strengthen the GPhC’s powers to introduce fair and proportionate language controls. In future, only pharmacy professionals who have a sufficient knowledge of the English language for safe and effective pharmacy practice will be eligible to register and work in Great Britain. This English language requirement will apply to all applicants and registrants, including those qualified in the European Economic Area (EEA) and Switzerland.

2.3 To comply with article 23A of the Pharmacy Order\(^1\) we consulted on draft guidance about the evidence, information and documents that may be provided by an applicant or registrant for the purpose of satisfying the Registrar that they have the necessary knowledge of English and the process by which the Registrar will determine whether he is satisfied that the person has this knowledge.

2.4 This report provides a summary of the responses to the consultation and a commentary in relation to our proposals.

2.5 The responses we received were broadly supportive of the proposals, and we have decided to go ahead with the proposed guidance, with a number of minor clarifications.

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\(^1\) Article 23A of the Pharmacy Order is introduced by the Health Care and Associated Professions (Knowledge of English) Order SI 2015/806
2.6 We are grateful for the feedback we have received. We will continue to keep the content of our guidance under review.

2.7 Alongside the consultation on draft guidance on evidence of English language skills, we consulted on amendments to the following rules:

- The General Pharmaceutical Council (Registration) Rules 2010 (SI 2010/1617)
- The General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010 (SI 2010/1615)

2.8 The main purpose of these proposals was to implement the statutory requirements for a registrant to have an appropriate indemnity arrangement in force and to have the knowledge of English necessary for safe and effective practice, as conditions of their registration with us. The changes would also introduce measures to avoid conflicts of interest arising from common membership of Appeals Committee and Fitness to Practise Committee panels. The report of that consultation can be found here link.
3. Background

3.1 The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacies in Great Britain. It is our job to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmacy services in England, Scotland and Wales.

3.2 We regulate pharmacists and pharmacy technicians in community and hospital settings. We also regulate practice within academia, research, public health, commissioning, management, industry and other settings where the public rely indirectly, but no less significantly, on the professionalism and competence of pharmacy professionals in a wide range of non-clinical roles. We also set standards for registered pharmacies.

3.3 Our core functions include:

- setting the standards of education and training which pharmacists and pharmacy technicians must meet in order to join our register and remain registered throughout their professional life
- registering pharmacists and pharmacy technicians and setting the standards of conduct and performance which they must meet to stay on our register
- setting standards for the safe and effective practice of pharmacy at registered pharmacies
- registering pharmacies which meet those standards and inspecting them to check that they continue to do so
- taking action when our standards are not met, typically through fitness to practise proceedings and enforcement action

3.4 Further information about the work of the GPhC can be found on our website [www.pharmacyregulation.org](http://www.pharmacyregulation.org)

3.5 We aim to make sure that regulation is fair and proportionate – taking into account the risk posed to the health, safety and wellbeing of patients and other pharmacy service users – and not over-burdensome. We want it to be flexible enough to respond to the changing demands made of the profession by governments on behalf of the public, and allow for innovation, while at the same time maintaining high quality practice.

3.6 The main pieces of legislation governing the GPhC are the Pharmacy Order 2010 (SI 2010/231) and the Medicines Act 1968 (c. 67). More detailed provisions relating to our regulatory functions are set out in statutory instruments called ‘rules’.
3.7 It has been a long established requirement of professional ethics that healthcare professionals should have sufficient English language competence for safe and effective practice. The General Pharmaceutical Council’s (GPhC’s) Standards of Conduct, Ethics and Performance\(^2\) require all registrants to communicate effectively with patients and pharmacy service users and to work in partnership with them and other healthcare professionals to manage their treatment and care. If a registrant does not have the necessary knowledge of English, there is a risk that they may not be able to act in the best interests of patients, which could compromise patient safety and lead to a fitness to practise investigation.

3.8 The Health Care and Associated Professions (Knowledge of English) Order 2015\(^3\) amends the Pharmacy Order and makes it a legal requirement for all registrants and applicants to have the necessary knowledge of English for safe and effective practice as a condition of registration with us. Previously, if a pharmacy professional was a national of the European Economic Area (EEA) or Switzerland, the Pharmacy Order prevented us from checking their English language skills before we registered them. We were only able to check the English language skills of non-EEA nationals, who qualified outside the EEA.

3.9 The Knowledge of English Order improves public protection. It enables us to introduce fair and proportionate language controls that would apply to all registrants and applicants for registration irrespective of nationality or country of qualification and gives the Registrar powers to request evidence or information about a pharmacy professional’s knowledge of English in certain circumstances. It also creates a new category of impairment of fitness to practise, relating to English language competence. This will allow us to initiate fitness to practise proceedings in cases where a pharmacy professional’s knowledge of the English language may pose a serious risk to patient safety.

3.10 The Knowledge of English Order also requires the GPhC to consult on and publish guidance setting out the evidence, information or documents that an applicant or registrant may provide to demonstrate that they have the necessary knowledge of English for safe and effective practice as a pharmacist or a pharmacy technician, and the process by which the Registrar will determine whether he is satisfied that the person has this knowledge.


3.11 Alongside the consultation on draft guidance on evidence of English language skills, we consulted on amendments to the following rules:

- The General Pharmaceutical Council (Registration) Rules 2010 (SI 2010/1617)
- The General Pharmaceutical Council (Fitness to Practise and Disqualification etc.) Rules 2010 (SI 2010/1615)

3.12 The main purpose of these proposals was to implement the statutory requirements for a registrant to have an appropriate indemnity arrangement in force and to have the knowledge of English necessary for safe and effective practice, as conditions of their registration with us. The changes would also introduce measures to avoid conflicts of interest arising from common membership of Appeals Committee and Fitness to Practise Committee panels. The report of that consultation can be found here link.
4. Who we heard from

4.1 We received a total of 116 responses to this consultation.

4.2 108 of these were submitted online. Eight responses were submitted by email. Four of the email responses addressed all or most of the consultation questions and were thus analysed alongside the online responses. The remaining four either provided general comments, duplicated an existing online response, or acknowledged the consultation but did not provide a comment.

4.3 We received a total of 17 responses from organisations and 74 responses from individuals over the course of the 12-week consultation. The remainder of the respondents did not indicate whether they were responding on behalf of an organisation or as an individual.

4.4 Six respondents identified their location to be outside of Great Britain.

4.5 62 of those responding “as an individual” identified themselves as pharmacy professionals, while five identified themselves as members of the public.

4.6 A detailed breakdown of respondents’ profile can be found in Appendix 1. A full list of the organisations that responded to the consultation can be found in Appendix 2.
5. **What we heard and our response**

5.1 This section sets out the number of responses we received for each question, a summary of the main points we heard and our response to these. The responses have helped to identify how the guidance can be clarified.

5.2 There was some repetition in the further comments we received, with many of the same issues appearing across different questions. Therefore, some of the comments made have been reported where they best fit.

**Criteria for assessing language evidence – Question 1**

5.3 In the draft guidance we proposed that for the evidence of language competence to be acceptable, an applicant must provide evidence of English language competence in the same four areas of reading, writing, listening and speaking in English as would be tested by the International English Language Testing System (IELTS) test. We also proposed that the evidence should:

- be recent, objective, independent and robust
- clearly demonstrate that the applicant can read, write and communicate with patients, pharmacy service users, relatives and healthcare professionals in English, and
- be readily verifiable by us

**In Question 1 we asked**

5.4 Do you agree that these proposed criteria will provide the Registrar with adequate assurance that an applicant or registrant has the necessary knowledge of English for the safe and effective practice of pharmacy?

<table>
<thead>
<tr>
<th>Responses to Question 1</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>82</td>
<td>74%</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Total number of responses</strong></td>
<td><strong>111</strong></td>
<td><strong>100%</strong></td>
</tr>
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5.5 Most respondents – around three-quarters (74%) – agreed with our proposed criteria. Less than a fifth of respondents (17%) disagreed.

5.6 One respondent requested clarity on the definition of ‘recent’ here.

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4 Please note, all percentages in the report have been rounded to the nearest whole number.
Our response

5.7  We will clarify in the ‘Criteria for assessing language evidence’ section of our guidance that when we refer to the evidence being ‘recent’, we mean evidence relating to English language competence that is less than 2 years old at the point of making an application to the GPhC.

Types of evidence we will accept to demonstrate knowledge of English – UK qualified applicants

5.8  In our draft guidance we proposed that UK qualified pharmacy professionals who provided documentary evidence of having successfully completed the relevant approved qualifications, taught and examined in English, under the supervision of a registered pharmacist, in line with our registration criteria, would not normally be required to provide additional evidence of their English language competence.

In Question 2 we asked

5.9  Do you think that our proposals for UK qualified applicants are clear?

<table>
<thead>
<tr>
<th>Responses to Question 2</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>88</td>
<td>81%</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10</td>
<td>9%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>108</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.10  The large majority of respondents (81%) agreed with our proposals for UK qualified applicants. The remaining respondents either disagreed (9%) or did not have an opinion on the issue (9%).

5.11  Four respondents who provided further comments felt that UK qualified applicants should also be required to pass an IELTS test.

5.12  One respondent commented:

“It would be helpful to understand when UK qualified applicants would need to demonstrate additional evidence of their English language competence...”

5.13  Two respondents recommended that the level of English language competence required for entry onto a university pharmacy degree programme and pharmacy technician training courses be made explicit. A further respondent sought assurance that appropriate English
language competence is covered by the GPhC as part of their accreditation/outcomes assessment process for schools of pharmacy.

Our response

5.14 In our view, it would not be proportionate to require UK qualified applicants to pass the IELTS test as a matter of course.

5.15 In our guidance we say that UK qualified pharmacy professionals will, in most cases, automatically satisfy the Registrar that they meet the English language requirements for registration. Examples of when we may require further evidence would be:

• if we received concerns about an individual’s English language competence during their education and training, or

• if a UK-qualified pharmacy professional applied to return to the register, having spent a significant period of time abroad in a country where English was not the first and native language

5.16 Requests for further evidence would be determined on a case by case basis, as relevant.

5.17 With regard to pharmacists, the GPhC’s initial education and training standard 4.2 requires that the Higher Education Institution selection criteria must be explicit and must include English language requirements appropriate to an MPharm degree study. Guidelines issued by English language testing bodies should be followed to ensure that admissions language requirements are appropriate.

5.18 With regard to pharmacy technicians, the GPhC’s initial education and training standard 9 requires that the entry requirements for the recognised knowledge based qualification (National Diploma in pharmaceutical science in England and Wales/ National Certificate pharmacy services in Scotland) require entrants to demonstrate a standard of English literacy and numeracy supported by the general equivalent to 4 GCSEs at grade A*-C.

5.19 Both of these requirements are explicit for all applicants wishing to complete these qualifications.

Types of evidence we will accept to demonstrate knowledge of English – non-UK qualified applicants

5.20 In our draft guidance we proposed that non-UK qualified applicants would be required to provide one of three possible types of evidence:

• Evidence type 1: A recent pass of the academic version of the International English Language Testing System (IELTS) test with an overall score of at least 7 and with no score less than 7 in each of the four areas of reading, writing, listening and speaking at one sitting of the test.
• Evidence type 2: A recent pharmacy qualification that has been taught and examined in English from a country (other than the UK) where English is the first and native language.

• Evidence type 3: Recent practice for at least two years as a pharmacy professional in a country where English is the first and native language.

In Question 3 we asked

5.21 Do you agree that all non-UK qualified applicants should be required to provide the same type of evidence as specified under type 1, 2 or 3 in the guidance to demonstrate their knowledge of the English language?

<table>
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<tr>
<th>Responses to Question 3</th>
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<th>% of respondents</th>
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<tbody>
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<td>76%</td>
</tr>
<tr>
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<td>17%</td>
</tr>
<tr>
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<td>7%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>103</td>
<td>100%</td>
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</tbody>
</table>

5.22 Over three-quarters of respondents (76%) agreed with our proposals for non-UK qualified applicants. Less than a fifth (17%) disagreed.

5.23 A number of respondents provided further comments to this question. These included:

• A suggestion that a lower score than an overall score of 7 in the academic IELTS test should be acceptable.

• On the other hand, others wondered why we would accept a lower score compared with the score used by the General Medical Council (GMC)\(^5\).

• A suggestion that all non-UK qualified applicants should be required to pass the IELTS test, irrespective of country of qualification.

• A suggestion that the IELTS scores required for safe practice may vary for each of the four skills - reading, writing, listening and speaking in English - and a recommendation that these be reviewed to ensure they continue to be appropriate.

• A suggestion that the GPhC consider accepting English language tests other than the IELTS, such as the Occupational English Test (OET) and the Cambridge Advanced English (CAE) Test.

\(^5\) The General Medical Council requires an overall score of at least 7.5 in the academic level IELTS test and minimum scores of at least 7 in each of the four areas of reading, writing, listening and speaking in English.
• Requests to specify how recently a primary qualification that had been taught and examined solely in English in a country where English is the first and native language must have been obtained in order to be acceptable.

• Concern about the adequacy of accepting documentary evidence of recent practice of at least 2 years in a country where English is the first and native language.

• A query about what would happen in cases where English was an equal official language, as in Wales, for example, or in Quebec, province in Canada, and whether we would follow the GMC and provide a list of accepted countries where English is the first and native language.

• A query as to whether an internally set exam or face to face interview would be viable.

Our response

5.24 In developing our draft guidance on evidence of English language skills, we worked with the General Dental Council (GDC) and the Nursing and Midwifery Council (NMC), building on the guidance developed by the GMC, and on what we each currently require from our internationally qualified applicants.

5.25 The predecessor of the GPhC, the Royal Pharmaceutical Society of Great Britain, introduced a requirement for all internationally qualified pharmacists (excluding European applicants) to provide evidence of their English language competence as part of their application for eligibility to start the Overseas Pharmacists’ Assessment Programme (OSPAP). All such applicants were required to pass the academic version of IELTS test with an overall score of at least 7 and with no score less than 7 in each of the four areas of reading, writing, listening and speaking, at one sitting of the test.

5.26 Based on our experience of assessing language evidence from OSPAP applicants, our view is that an overall score of at least 7 in the academic version of the IELTS test, with no score less than 7 in each of the four areas of reading, writing, listening and speaking, at one sitting of the test, is the minimum score we would accept for registration purposes. It is also the same level that the NMC and GDC have set for nurses and midwives, and for dentists applying to join their respective registers.

5.27 In relation to evidence of a recent pharmacy qualification that has been taught and examined in English, we will clarify that by a ‘recent pharmacy qualification’ we mean a pharmacy qualification that was completed no more than 2 years ago at the point of making an application to the GPhC.

5.28 In relation to the adequacy of accepting documentary evidence of recent practice of at least 2 years as a pharmacy professional in a country where English is the first and native language, we intend providing further guidance. Employer(s) will be required to provide detailed written evidence of how the applicant has demonstrated their ability in the English language in the four areas of reading, writing, listening and speaking.
5.29 We are conscious that Welsh has equal legal status to English in Wales. However, the relevant European Directive, implemented by the Knowledge of English Order, states that Member States may only introduce language controls on one language per Member State. English is most appropriate for Great Britain.

5.30 In relation to whether a face to face interview would be a viable option, our requirements concerning evidence of English language competence are not designed to replace the important role that employers must continue to play in checking that the pharmacy professionals they seek to employ have the necessary knowledge of English to practise safely and effectively in the role, as part of their interview and selection processes.

5.31 We are committed to review our English language evidence requirements on a regular basis to ensure they remain suitable. We will give full consideration to new sources of evidence that can provide the necessary assurance that applicants and registrants have the necessary knowledge of English for safe and effective practice.

In Question 4 we asked

5.32 Do you agree that non-EEA qualified pharmacists applying for the OSPAP should be able to demonstrate their knowledge of the English language by providing either type 2 or 3 evidence as specified in the guidance?

<table>
<thead>
<tr>
<th>Responses to Question 4</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76</td>
<td>80%</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>95</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.33 The large majority of respondents (80%) agreed with our proposal that non-EEA qualified pharmacists applying for the OSPAP should be able to provide either type 2 or 3 evidence. This would be instead of requiring all such applicants to provide evidence that they have passed the academic version of the IELTS test and achieved the required scores in one sitting. Less than a fifth of respondents (17%) disagreed.

5.34 Three respondents who provided further comments were of the opinion that all pharmacists applying for the OSPAP should be required to pass the IELTS test and achieve the requisite standard. One respondent commented that the requirement to pass the academic level IELTS test and achieve an overall score of at least 7 with no score below 7 in each of the four test parameters was too high.
Our response

5.35 The responses we received were broadly supportive and we intend to permit applicants for the OSPAP to provide any one of the three possible types of evidence instead of requiring all such applicants to provide evidence that they have passed the academic version of the IELTS test and achieved the required scores in one sitting of the test.

In Question 5 we asked

5.36 Do you agree that, where relevant, non-UK qualified pharmacy technicians will be required to achieve the same scores in the academic version of the IELTS test as non-UK qualified pharmacists?

<table>
<thead>
<tr>
<th>Responses to question 5</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>72</td>
<td>77%</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>13%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>93</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.37 Most respondents (over three-quarters, 77%) agreed that, where relevant, non-UK qualified pharmacy technicians should be required to achieve the same IELTS test scores as non-UK qualified pharmacists. Thirteen percent (13%) disagreed with the proposal.

5.38 Eight of the respondents providing further comments were of the opinion that pharmacy technicians should be required to demonstrate the same level of English language proficiency as pharmacists.

Comments included:
- ‘they [pharmacy technicians] have just as much, if not more contact with patients’
- ‘they also provide often complex and sensitive information to other healthcare professionals’
- ‘we would support an equitable and standard approach to assessing language competence for all those on the register’

5.39 Other respondents felt that the language skills required of pharmacy technicians to perform their job safely and effectively might be different from those of pharmacists and suggested that a standard setting study and research be conducted to establish the appropriate level.
5.40 Some felt that it might be harder for non-UK qualified pharmacy technicians to achieve the required scores in the IELTS test and that this requirement may be a considerable change for non-UK qualified pharmacy technicians, more so than for non-UK qualified pharmacists.

5.41 One respondent suggested, for example, that pharmacy technicians should be required to achieve an IELTS test score of 6.

5.42 However, another respondent felt that the acceptable test score should be the same as that set by the GMC, which is a minimum score of 7 in each area of the test with an overall score of at least 7.5.

**Our response**

5.43 The responses received were broadly supportive of our proposal. Both pharmacists and pharmacy technicians work with patients, carers, their families and other healthcare professionals in a variety of settings. Both should be required to demonstrate the same level of English language competence.

5.44 We will monitor the impact of our guidance and will keep the content under review.

**When to provide evidence of knowledge of English for first registration – Question 6**

5.45 In our draft guidance we proposed that where an EEA qualified pharmacy professional is required to complete a compensation measure we will ask them to provide evidence of their English language competence that meets our requirements before they can start working in a supervised capacity with patients, carers, their families, and other healthcare professionals.

**In Question 6 we asked**

5.46 Do you agree that EEA qualified applicants, who are required to complete a compensation measure under the General System provisions\(^6\), should be required to provide evidence of their knowledge of English before they can start to work in a supervised capacity?

<table>
<thead>
<tr>
<th>Responses to question 6</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>77</td>
<td>84%</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>92</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^6\) Articles 10 to 14 of Directive 2005/36/EC on the recognition of professional qualifications.
5.47 A large majority of respondents (84%) agreed with this proposal. Around a tenth (11%) disagreed.

5.48 12 respondents who provided further comments supported this proposal, with one respondent suggesting that inadequate language capability will make it difficult to acquire the knowledge and skills required by the compensation measure.

5.49 Other comments received included:

- ‘We agree that it is sensible to assess that the English language competence of the individual meets requirements before they start working in a supervised capacity with patients. Although providing evidence of English competence is the first step, the supervising pharmacist should then give assurance of appropriate consultation skills.’

- ‘Whilst we agree with this approach in principle, we are not sure it is appropriate or fair – under European equivalence arrangements – that English language assessment takes place before entering practice, if the same requirement is not also imposed on anybody entering supervised practice prior to registration (in GB training)”

Our response

5.50 In our opinion, requiring EEA qualified pharmacy professionals to provide evidence of English language competency before they start a period of supervised practice is equitable and proportionate and is equivalent to the requirements imposed on non-EEA qualified pharmacists. Non-EEA qualified pharmacists are required to provide evidence of their English language competence before starting the Overseas Pharmacists’ Assessment Programme (OSPAP).

5.51 It is also important to note here that our requirements concerning evidence of English language competence are not designed to replace the important role that employers must continue to play in checking that the pharmacy professionals they seek to employ have the necessary knowledge of English to practise safely and effectively in the role, as part of their interview and selection processes.

Renewal of registration- Question 7

5.52 Our draft guidance proposes that, at renewal, registrants would be required to specify whether they have evidence, information or documents demonstrating that they have the necessary knowledge of English. We are also proposing that registrants would be required to provide this evidence, if requested to do so by the Registrar.

In Question 7 we asked

5.53 Do you agree with the proposal that, at renewal, registrants would be required to:
• specify whether they had evidence to demonstrate their knowledge of the English language and
• provide this if requested to do so by the Registrar?

<table>
<thead>
<tr>
<th>Responses to question 7</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>48</td>
<td>53%</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>33%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12</td>
<td>13%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>90</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.54 This consultation proposal received the lowest number of responses in support. Just over a half of respondents (53%) agreed with the proposal. A third disagreed (33%). The remaining 12 respondents (13%) were unsure.

5.55 From a number of the further comments received, it was apparent that the wording of the guidance was insufficiently clear as to what would be required at annual renewal.

5.56 Comments received included:

• ‘We would urge this exercise to require minimal administration – for example a self-declaration question as part of the renewal form should suffice. It would be helpful to confirm which types of evidence the registrant to confirm they hold – we have understood these to be the same as for registration. For many registrants we would expect their current employment to meet the evidence requirement.’

• ‘The implication of this section of the guidance (and this question) is that on each annual renewal a registrant will be required to provide evidence. We do not believe that this is what is intended if the registrant is already on the register, has had their language skills assessed (or is UK –exempted) and is working in the UK.’

• ‘Only if concerns had been raised about the quality of their English language skills.’

Our response

5.57 The wording in this section of the guidance will be clarified. It is our intention that a registrant would be required to make a self-declaration as part of their application for renewal that they have the necessary knowledge of English for safe and effective practice and that, if requested to do so, they can provide the evidence, information or documents to support this declaration. They would not as a matter of routine be required to provide this evidence as part of the renewal process. A request for a registrant to provide evidence
could, for example, be made if a concern was raised that the registrant had insufficient knowledge of the English language.

**Returning to the register- Question 8**

5.58 In our draft guidance we proposed a number of criteria we would consider when determining whether a pharmacy professional would need to provide further evidence of their knowledge of English before returning to the register. The criteria included:
- the length of time they practised in GB before leaving the register
- the length of time off the register
- whether they had provided evidence of their English language competency at initial registration
- whether concerns had been raised about their English language competence while previously registered

**In Question 8 we asked**

5.59 Do you agree with our approach to requesting further evidence of knowledge of English before we return an applicant to the register?

<table>
<thead>
<tr>
<th>Responses to question 8</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>65</td>
<td>72%</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>20%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
<td>8%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>90</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.60 Just under three-quarters of respondents (72%) agreed with this proposal. A fifth disagreed.

5.61 Ten respondents who provided further comments supported this proposal and most were of the opinion that the sort of criteria we proposed taking into account seemed reasonable and, used as guidance to consider applications for return to the register, appeared fair and sufficiently flexible.

5.62 Comments received in support included:
- ‘The approach looks reasonable and flexible to meet the many reasons and circumstances in which an individual may have lapsed their registration. We did wonder whether the inclusion of an indicative time-scale would be helpful and clarity on the range of evidence the GPhC will accept as evidence of English language skills.’
• ‘We agree with the approach concerning knowledge of English in relation to those seeking readmission to the register. We agree that a range of criteria should be considered for demonstrating competence in English and would suggest that clear guidelines be developed in relation to these in order to protect the interests of registrants and of the public alike.’
• ‘Each case may be different but guidelines such as these seem a good way forward.’

5.63 Other comments included:
• ‘Unless they were struck off for not being able to speak any English at all, there is no reason at all to go through that lengthy process.’
• In relation to proportionality: ‘Is it expected that this would apply to all returnees or only those who initially qualified outside the UK.’

Our response

5.64 The proposed process will apply to all persons applying to return to the register. Some pharmacy professionals apply to return to the register soon after their registration has lapsed, while others do so after having been off the register for a more significant period of time - for example, after having spent time practising abroad, or when returning to practice after a career break. Our guidance will include a non-exhaustive list of criteria which will give an indication to persons applying to return to the register of the matters we will take into account in determining whether to request further evidence of their knowledge of English before granting their application.

Concerns about language competence- Question 9

In Question 9 we asked

5.65 Do you agree that where there is an allegation or concern about a registrant’s knowledge of English the registrant can be required to undertake the academic version of the IELTS test and achieve the required scores in one sitting?

<table>
<thead>
<tr>
<th>Responses to question 9</th>
<th>No. of respondents</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>66</td>
<td>74%</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>89</td>
<td>100%</td>
</tr>
</tbody>
</table>

5.66 Around three-quarters (74%) of respondents agreed with this proposal. Less than a fifth (17%) disagreed.
A number of respondents queried whether it would be the registrants’ responsibility or the GPhC’s responsibility to cover the cost of the IELTS test if the registrant was requested to take this test.

Our response

Where an individual is making an application for registration or return to the register and they are requested to take an IELTS test to demonstrate that they have the necessary knowledge of English for safe and effective practice, then it would be for the individual concerned to pay for the test.

Where the GPhC receives a concern or allegation that a registrant may be practising and may not have the necessary knowledge of English, then the concern or allegation would be triaged and investigated in the same way as any other concerns or allegations we receive.

Where, as part of that investigation, the Registrar, Investigating Committee, or Fitness to Practice Committee requires the pharmacy professional to take the IELTS test and provide the results of that test to the GPhC, then the cost of that test would be borne by the GPhC.

It is important to note that employers have always been responsible for ensuring that any individual they employ has the necessary competence, including language competence, to carry out the duties they will be required to undertake. The Knowledge of English Order and our guidance do not replace this important role that employers must continue to play.
Appendix 1: Profile of individual respondents

Responses received from pharmacy professionals and members of the public

The breakdown of pharmacy professionals and members of the public who responded to the consultation are detailed in the table below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>55</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td>6</td>
</tr>
<tr>
<td>Member of the public</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>1 (pharmacist/doctoral researcher)</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>67</strong></td>
</tr>
</tbody>
</table>

Location of respondents

We received responses to the consultation from across England, Scotland and Wales.

We received 6 responses categorised as ‘other’; 1 each from Australia, Germany, Italy and Spain, and 2 from Romania.

<table>
<thead>
<tr>
<th>Location</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>52</td>
</tr>
<tr>
<td>Scotland</td>
<td>2</td>
</tr>
<tr>
<td>Wales</td>
<td>3</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total number of respondents</strong></td>
<td><strong>63</strong></td>
</tr>
</tbody>
</table>

7 Please note, the total number of respondents differs from question to question, as not all respondents answered these questions.
Appendix 2: Organisations that responded to the consultation

Responses from organisations

We received responses on behalf of 17 organisations. These are listed in the table below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Area Pharmaceutical Professional Committee, University Hospital Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>2</td>
<td>Association of Pharmacy Technicians UK (APTUK) (email)</td>
</tr>
<tr>
<td>3</td>
<td>Aneurin Bevan Community Health Council (email)</td>
</tr>
<tr>
<td>4</td>
<td>Boots UK</td>
</tr>
<tr>
<td>5</td>
<td>Cambridge English Language Assessment</td>
</tr>
<tr>
<td>6</td>
<td>Celesio UK</td>
</tr>
<tr>
<td>7</td>
<td>Community Pharmacy Wales (email)</td>
</tr>
<tr>
<td>8</td>
<td>Grossman Pharmacy</td>
</tr>
<tr>
<td>9</td>
<td>Guild of Healthcare Pharmacists</td>
</tr>
<tr>
<td>10</td>
<td>Manchester Pharmacy School, The University of Manchester</td>
</tr>
<tr>
<td>11</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>12</td>
<td>NHS Employers</td>
</tr>
<tr>
<td>13</td>
<td>North Wales Community Health Council</td>
</tr>
<tr>
<td>14</td>
<td>OET - Occupational English Test</td>
</tr>
<tr>
<td>15</td>
<td>Pharmacy Voice (email)</td>
</tr>
<tr>
<td>16</td>
<td>Rowlands Pharmacy</td>
</tr>
<tr>
<td>17</td>
<td>Royal Pharmaceutical Society</td>
</tr>
</tbody>
</table>
Evidence of English Language skills: Ensuring pharmacy professionals have the necessary knowledge of English to practise safely in Great Britain.

Introduction

1. It has been a long established requirement of professional ethics that healthcare professionals should have sufficient English language competence for safe and effective practice. The General Pharmaceutical Council’s (GPhC’s) Standards of Conduct, Ethics and Performance requires all registered pharmacy professionals to communicate effectively with patients and pharmacy service users and to work in partnership with them and other healthcare professionals to manage their treatment and care. If a registrant does not have the necessary knowledge of English there is a risk that they may not be able to act in the best interests of patients which could compromise patient safety and lead to a fitness to practise investigation.

2. The Health Care and Associated Professions (Knowledge of English) Order 2015 amends the Pharmacy Order and makes it a legal requirement for all registrants and applicants to have the necessary knowledge of English for safe and effective practice as a condition of registration with us. Previously, if a pharmacy professional was a national of the European Economic Area (EEA) or Switzerland, the Pharmacy Order prevented us from checking their English language skills before we registered them. We were only able to check the English language skills of non-EEA nationals who qualified outside the EEA.

3. The Knowledge of English Order improves public protection. It enables us to introduce fair and proportionate language controls that would apply to all registrants and applicants for registration irrespective of nationality or country of qualification and gives the Registrar powers to request evidence or information about a pharmacy professional’s knowledge of English in certain circumstances.

How this change will affect you

4. Article 23A of the Pharmacy Order 2010 requires the Council to publish guidance setting out the evidence, information or documents you must provide to show you have the necessary knowledge of English to practise safely in Great Britain and the process to be followed when making that determination.

5. The law and guidance applies to registrants and to all applicants seeking registration. It therefore applies:

3. Article 23A of the Pharmacy Order was introduced by the Knowledge of English Order
• irrespective of whether you are applying to register as a pharmacist or pharmacy technician and
• irrespective of whether you qualified as a pharmacy professional:
  • in the United Kingdom (UK),
  • in another European Economic Area (EEA) member state or Switzerland, or
  • in a country outside of the UK, EEA or Switzerland.

6. The Registrar must take account of this guidance when deciding whether you have shown that you have the necessary knowledge of English. The Registrar can refuse to register you if you do not provide evidence of your knowledge of English or where the evidence you provide does not meet the criteria set out in this guidance.

Criteria for assessing language evidence

7. Our criteria for assessing evidence and information in relation to knowledge of English are set out below. The criteria reflect our objective of ensuring patient safety and provide us with adequate assurance that you have the necessary knowledge of English\(^4\) for the safe and effective practice as a pharmacy professional in Great Britain before we can register you.

8. The evidence you provide must demonstrate your competence in the four areas of:
   • Reading
   • Writing
   • Listening and
   • Speaking in English

and must:
   • be recent\(^5\), objective, independent and robust;
   • clearly demonstrate that you can, read, write and communicate with patients, pharmacy service users, relatives and healthcare professionals in English; and
   • be readily verifiable by us.

Types of evidence we will accept to demonstrate your knowledge of English

UK qualified applicants

9. If you are a UK qualified applicant wishing to register as a pharmacist having completed:
   • a GPhC accredited Master of Pharmacy degree from a university within the UK and
   • pre-registration training and the registration assessment within the UK

you will in most cases automatically satisfy the Registrar that you meet the English language requirements for registration.

\(^4\) Article 3(1) and Article 20(1)(a)(iia) and 2(a)(iia) of the Pharmacy Order 2010 introduced by the Knowledge of English Order.

\(^5\) When we refer to ‘recent’ we mean evidence relating to English language competence that is less than 2 years old at the point of making an application to the GPhC.
10. If you are a UK qualified applicant wishing to register as a pharmacy technician having completed:

- an approved knowledge and competency qualification in the UK while working under the supervision, direction or guidance of a registered pharmacist in Great Britain, Northern Ireland, the Channel Islands or the Isle of Man

you will in most cases automatically satisfy the Registrar that you meet the English language requirements for registration.

Non-UK qualified applicants

11. There are different ways in which you may be able to demonstrate that you have the necessary knowledge of English to practise in Great Britain and this is reflected in the types of evidence we will accept.

12. We will review our English language evidence requirements on a regular basis to ensure they remain suitable. We will give full consideration to new sources of evidence that can provide the necessary assurance that you have the necessary knowledge of English.

13. However, based on our experience of assessing language evidence from international pharmacists qualified outside the EEA we have set out below the types of evidence we will accept as demonstrating that you have the necessary knowledge of English to practise as a pharmacy professional in GB.

Evidence type 1:

A recent pass of the academic version of International English Language testing System (IELTS) test with an overall score of at least 7 and with no score less than 7 in each of the four areas of reading, writing, listening and speaking at one sitting of the test.

14. We may accept IELTS test scores that are more than two years old if you can provide evidence to demonstrate that you have maintained your English language proficiency during that time. This can be for example if you have subsequently worked as a pharmacy professional in a country where English is the first and native language and at least 75% of your day to day interaction with patients, carers, their families and other healthcare professionals has been in English.

Evidence type 2:

A recent pharmacy qualification that has been taught and examined in English from a country (other than the UK) where English is the first and native language (e.g. Ireland, United States of America, Australia, New Zealand).

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6 When we refer to ‘recent’ we mean evidence relating to English language competence that is less than 2 years old at the point of making an application to the GPhC.

7 http://www.ielts.org/

8 First and native language is not the same as official language. The list of countries we accept is modelled on the UK Border Agency’s list of ‘majority English speaking countries’ plus Ireland (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340583/English_language_v11.0_EXT.pdf).
15. The entire course must have been taught and examined in English and at least 75% of any in-service training including clinical interaction, contact with patients, their carers and other healthcare professionals as part of that course of study must have been conducted in English.

16. You will need to be able to show that your training provided you with the opportunity to demonstrate your ability in reading, writing, listening and speaking in English.

Evidence type 3:

Recent practice for at least two years as a pharmacy professional in a country where English is the first and native language.

17. You will be required to provide a detailed written reference from your employer(s) as to your knowledge of English. As part of this reference an employer will be required to provide evidence of how you have demonstrated your ability in the four areas of reading, writing, listening and speaking in English.

18. If you were required to pass an English language test before being permitted to register and practise as a pharmacy professional in another country where English is the first and native language then you can provide evidence of having passed such an English language assessment.

When you need to provide evidence of your knowledge of English for first registration

This section describes how and when you will need to provide evidence or information to show whether you have the necessary knowledge of English for the safe and effective practice of pharmacy in Great Britain, and the process we will follow. The process will depend on where you qualified.

UK qualified applicants

19. If you are a UK qualified applicant the registration process has not changed since the English language requirements were introduced. As before you will need to submit documentary evidence of having successfully completed the relevant UK qualifications as set out in the criteria for registration as a pharmacist\(^9\) or pharmacy technician\(^10\) together with your application for registration. You must provide the evidence in the form and manner described in the registration application form and supporting guidance. You will not normally be required to provide further evidence of your English language ability.

20. Pharmacist applicants who had submitted a pre-registration training plan where they requested to complete up to 13 weeks of their pre-registration training placement in another European member state in accordance with the pre-registration training scheme\(^11\) and then passed the

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\(^9\) [http://www.pharmacyregulation.org/sites/default/files/Registration%20criteria%20for%20pharmacists%20September%202012_0.pdf](http://www.pharmacyregulation.org/sites/default/files/Registration%20criteria%20for%20pharmacists%20September%202012_0.pdf)

\(^10\) [http://www.pharmacyregulation.org/sites/default/files/Registration%20criteria%20for%20pharmacy%20technicians%20Dec%202013.pdf](http://www.pharmacyregulation.org/sites/default/files/Registration%20criteria%20for%20pharmacy%20technicians%20Dec%202013.pdf)

GPhC registration assessment will also not normally be required to provide additional evidence of their language ability with their application for registration.

Non-UK qualified applicants

21. If you are a non-UK qualified applicant, the process for providing evidence to demonstrate your knowledge of English will depend on whether you qualified:
   - in a country outside of the UK, EEA or Switzerland. If this applies you will need to follow the process described under non-EEA qualified applicants below
   - in the EEA or Switzerland and are covered by the provisions in Directive 2005/36/EC on the Recognition of Professional Qualifications (the Directive). If this applies you will need to follow the process described under EEA qualified applicants below.

22. Non-EEA qualified applicants

22.1 If you are a non-EEA qualified pharmacist you will need to provide evidence to demonstrate your knowledge of English as part of your application for eligibility to start the Overseas Pharmacists Assessment Programme (OSPAP).

22.2 If you are unable to provide evidence to satisfy the criteria under either the recent primary pharmacy qualification or recent practice as a pharmacist in a country where English is the first and native language you will be required to provide evidence of your English language proficiency by achieving the required scores in the academic version of the IELTS in one sitting of the test.

22.3 If you are a non-EEA qualified pharmacy professional and wish to register as a pharmacy technician, because you will first have to complete the same requirements as a UK qualified applicant described in paragraph 10, you will not normally be required to provide additional evidence of your language ability with your application for registration. As at present you will need to submit documentary evidence of having successfully met the criteria for registration as a pharmacy technician together with your application for registration. You must provide the evidence in the form and manner described in the registration application form and supporting guidance.

22.4 However if a situation arises during the registration process where you require the services of a translator or another person in order to communicate in English with us we will review the evidence that has already been provided. In these cases we are likely to request further evidence of your knowledge of English before granting registration.

23. EEA qualified applicants

23.1 If you are an EEA qualified pharmacist you are first required to make an application for recognition of your qualification. You are not required to provide evidence to show your knowledge of English when you make this application for recognition but you can do so if you wish.

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23.2 If we determine that your pharmacist qualification meets the requirements for automatic recognition under the Directive\textsuperscript{14}, we will inform you that we have recognised your qualification.

23.3 Where you had supplied evidence of your English language competence with your application for recognition and the Registrar determines that the evidence submitted meets our criteria and is described under types of evidence above, we will not normally request further evidence or information from you, and you can proceed to complete your application for registration.

23.4 Where
- you did not provide evidence to show your knowledge of English with your application for recognition or
- you did provide evidence but this does not satisfy the Registrar as to your English language competence,

we will still recognise your qualification, provided that this meets our requirements. We will write to you informing you of this and ask you to provide evidence of your language competence before you can progress on to registration. If you do not provide evidence of your knowledge of English with your initial application, this formal request for evidence cannot be made until we have recognised your qualification.

23.5 If you are an EEA qualified pharmacist or pharmacy technician and your application is being assessed via the EU General System provisions\textsuperscript{15} we will ask you to provide evidence of your English language competence before we authorise you to begin any required compensation measure. This is because we want to make sure that your English language competence meets our requirements before you start working in a supervised capacity with patients, carers, their families and other healthcare professionals.

23.6 If the Registrar is still not satisfied as to your English language competence after you have provided further evidence or information, or if you are unable to provide any evidence, we will ask you to pass the academic version of the IELTS test and achieve the required scores in one sitting before we can register you or before you can start the compensation measure where relevant.

**Renewal of registration**

24. In an application for renewal you will be required to specify, by way of a self-declaration, whether you have evidence, information or documents demonstrating that you have the necessary knowledge of English. You will only be required to provide this evidence if requested to do so by the Registrar.

\textsuperscript{14} For automatic recognition your qualification must be listed in Annex V 5.6.2 and comply with the minimum training requirements set out in Article 44 or you must be able to benefit from the acquired rights provisions set out in Article 23 of Directive 2005/36/EC.

\textsuperscript{15} Articles 10 to 14 of Directive 2005/36/EC.
Returning to the register

25. In cases where your registration has lapsed or you have voluntarily removed yourself from the register you may apply to the Registrar to return to the register and restore your entry. Some pharmacy professionals apply to return to the register soon after their registration has lapsed while others do so after having been off the register for a more significant period of time for example after having spent time practising abroad or when returning to practice after a career break.

26. If you are returning to the register we will consider the following criteria to determine whether you have shown that you have the necessary knowledge of English:

- The length of time since you last practised in GB
- Whether you had practised elsewhere or continued to live in GB whilst off the register
- Whether you had previously demonstrated English language competence at your initial registration
- The length of time you were registered and practising in GB
- Other information as may be relevant for example whether concerns were raised about your English language competence while previously registered.

27. This is not an exhaustive list but gives an indication of matters we will take into account in determining whether to request further evidence of your knowledge of English before returning you to the register.

Fees

28. If you are requested to pass the academic version of the IELTS test and achieve the required scores in one sitting before applying for registration or restoration, you must pay the fee for taking the IELTS test yourself.

Rights of appeal

29. Article 39 of the Pharmacy Order sets out that you have a right of appeal to the Appeals Committee where the Registrar makes the decision that he is not satisfied that you have the necessary knowledge of English and requires you to take an examination or assessment (the IELTS test).

If a concern about language competence is raised while you are on the register.

30. Under article 51(1)(ca) of the Pharmacy Order, your fitness to practise may be considered to be impaired on the basis that you do not have the necessary knowledge of English. If we receive an allegation or have concerns ourselves that you do not have the necessary knowledge of English and as a result your fitness to practise may be impaired then this will be treated as an allegation that will be dealt with via the fitness to practise process. Such cases will be dealt with in a similar way to any other allegation of impaired fitness to practise. If you are subject to such an
allegation or concern the Registrar, Investigating Committee or Fitness to Practise Committee can require you to be assessed as to your knowledge of English. If this happens you will be required to undertake the academic version of the IELTS test and achieve an overall score of at least 7 with no score less than 7 in each of the four areas of reading, writing, listening and speaking at one sitting of the test.
Public business

CPD framework consultation

Purpose
To provide Council with the proposed consultation on a change to the continuing professional development (CPD) framework so that sampling approach to calling and reviewing records can be introduced.

Recommendations
Council is asked to consider and approve the amended paragraph in the CPD framework for consultation.

1. Introduction
1.1 To improve regulatory effectiveness and proportionality of our work and impact on pharmacy professionals, a change to policy for calling and reviewing CPD records is being proposed.

1.2 The Pharmacy Order sets out a responsibility for Council to consult upon requirements, under article 5, and a specific duty to consult on the criteria for assessment of CPD set out in the CPD framework, under article 43.

2. A new approach to reviewing records
2.1 The new approach to reviewing records is being proposed primarily to improve effectiveness and proportionality of our work as a regulator. Evidence has been collected showing that our current approach does not have the impact on registrant behaviour that we would expect, and changing the approach will have a positive impact on our registrants and their reflection on learning and development activities.

2.2 Secondary to the improvements in our effectiveness as a regulator in encouraging professional behaviours, there are efficiency gains to be made to internal operations as a result of this change which are outline below in paragraphs 6.2 and 6.3.

2.3 The current wording of the CPD framework in paragraph 3.1 sets the expectation that all registrants will have their CPD records called and
reviewed at least every five years. Over the last five years, we have reviewed the records of every eligible registrant.

### 2.4 Over the course of the development of a new approach to further assure standards for pharmacy professionals throughout careers, it was recommended that an annual randomised sample alongside a purposive sample would produce better outcomes for engagement and reflection from registrants.

### 2.5 In preparation for a change to policy, Council initiated a pilot study of a sampling approach to calling records. The following method of registrant selection for review of records was used:

1. random selection of 2.5% of all eligible registrants (n = 1264)
2. all eligible registrants from the last five years who had previously required a period of remediation before meeting CPD requirements (n = 432)
3. all registrants who had recently been restored to the register and had not yet had their CPD records reviewed (n = 104)

### 2.6 The pilot study demonstrated that registrants selected at random or because they have been restored to the register continue to meet requirements at a level consistent with how they performed under our current five year cycle. However registrants who had previously needed a period of remediation in the last cycle had a significantly increased likelihood of needing remediation again.

### 2.7 Based on the pilot study paragraph 3.1 of the CPD framework has been amended to allow flexibility to use random sampling, which is a change to current policy. The wording has been selected to allow for a responsive approach to sampling so that a larger proportion of registrants can be selected at random. For example, if it was found registrants were increasingly finding it difficult to meet requirements for CPD, we may choose to increase the sample size in the following year to provide further assurances.

### 2.8 The wording of the paragraph already made provision for selecting registrants for review more regularly for a number of reasons and this wording has been maintained, so there is no change to policy on the matter of purposive selection.

### 3. Rationale for the amended wording

#### 3.1 The evidence supporting making this amendment is largely drawn from a qualitative review of our current approach to CPD. The review drew attention to a number of improvements that can be made to how we deliver assurance around CPD activities. Not least of these was the relatively consistent message from pharmacy professionals who were interviewed that, although
undertaking CPD on a continuous basis was valued, recording of it was often only done in response to a call to submit records.

3.2 We heard in the review that we needed to change our approach to encourage continuous recording and that using a random annual sample will change how our registrants perceive how regularly they may be called to submit their records.

3.3 This will mean registrants may be called more regularly than every five years. It may also mean that registrants may be called less frequently than five years. However, we intend over time to enhance the sampling approach to increase the likelihood of selection based on a number of factors including time since last review. The wording of the amended paragraph allows for these future enhancements without needing further consultation.

3.4 In reducing the resources we spend on checking records across the whole register, we can focus attention on those registrants who find it harder to meet our requirements. This is a more proportionate use of our own resources.

3.5 We also intend over time to increase our evidence base to support improved risk based purposive sampling so that we can further focus attention where it can make the most difference. For example, we may wish to call registrants who fail to meet deadlines for submission of CPD records more regularly.

4. Equality and diversity implications

4.1 An equality analysis has been drafted. We did not identify any implications that would discriminate or unintentionally disadvantage any individuals or groups because the only change to policy is to introduce a randomised (and inherently unbiased) sample. All other parts of the policy, including routes to seek reasonable adjustments, remain consistent with current policy. However, the consultation document seeks views on issues of equality impact through specific questions about the impact on differing groups.

5. Communications

5.1 A specific communications plan has been produced for the period of consultation (6 weeks). The scope of the consultation is relatively narrow yet the impact is across our whole register. Therefore, the intention is that engagement with pharmacy and patient representative organisations will be pro-active and relatively individualised to facilitate responses being made.

5.2 Engagement over this matter has been continuous during the course of the development of our approach to further assuring standards for pharmacy professionals throughout careers through the advisory group.

5.3 A key message is that a randomised sampling approach coupled with purposive sampling will provide additional assurances rather than reduce
them. Our registrants, as a result of the change, will be more likely to be recording their CPD on at least an annual basis rather than every five years.

6. Resource implications
6.1 The resources for this work have been accounted for in existing budgets.
6.2 Although the primary purpose of this change to policy is to improve regulatory effectiveness and proportionality, there are secondary resource savings related to the costs of reviewing records. An estimated saving of c £200,000 per year will be made following a change to policy if it is agreed by Council.
6.3 There will be no reduction in the overall time to complete CPD entries for our registrants at this time (these changes will come later through the introduction of simplified recording forms as part of the continuing fitness to practise development programme). However the work to record entries will now be more likely to take place closer to the time of a CPD activity reducing the chance that registrants need to make five years of records in one sitting and improving the quality of reflection on learning activities.

7. Risk implications
7.1 As with all consultations, there is a risk that the proposals will not be properly understood or accepted. Work to mitigate this has been ongoing through the network development around the advisory group of pharmacy organisations and patient representatives. And the communications plan will ensure that we engage with key stakeholders over the course of the consultation period.

8. Monitoring and review
8.1 The outcomes of the consultation for pharmacy professionals will be reviewed in winter 2016.
8.2 The CPD framework document will be subject to further consultation in spring 2017 when broader changes are proposed following evaluation of the proposals for providing further assurance of standards for pharmacy professionals throughout careers.

Recommendations
Council is asked to consider and approve the amended paragraph in the CPD framework for consultation.

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25 August 2016
Consultation on sampling continuing professional development records for review

September 2016
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The deadline for responding to this consultation is Day Date Month 2016.
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.
Overview

The GPhC is consulting until [Day Date Month] 2016 on a new approach to calling continuing professional development records, completed by pharmacy professionals, for review. You can find out more about how we currently do this by visiting this page of our website: [INSERT WEBSITE HERE]

We are the regulator for pharmacists, pharmacy technicians and registered pharmacies in Great Britain. It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public, and in particular those who use or need the services of pharmacy professionals or the services provided at a registered pharmacy.

One of the ways we do this is by requiring all pharmacists and pharmacy technicians to undertake continuing professional development activities on an annual basis and by asking registrants to submit their records for review normally every five years.

99.7% of all the pharmacy professionals’ records we checked over the last five years met our requirements at the first attempt.

We have learnt that our current approach of checking all pharmacy professionals every five years is not proportionate or effective at driving the professional behaviours of recording and reflecting upon learning and development activities.

In future we do not want to call in the CPD records of all pharmacy professionals but instead randomly select a smaller portion of pharmacy professionals on an annual basis and request their records are submitted to us for review. We also want to continue to select pharmacy professionals who previously had difficulty meeting our requirements to make sure they have improved their recording of activities.

We have evidence from research and pilot study conducted in 2016 to show that this is likely to mean that pharmacy professionals will still undertake and record their continuing professional development activities and allow us to focus our attention toward the 0.3% who find it more challenging to meet our requirements.

This consultation document has two sections:

What we are changing and why: this explains what we currently do and propose to do; it sets out what we have taken into account when considering making the change; and it explains why we want to make a change.

The change to the continuing professional development framework: this includes the draft change to the continuing professional development framework and what it means about how it will work in practice.
The consultation process

The GPhC has considered a range of information in developing this consultation, in particular the feedback we received from our review of our current continuing professional development requirements [INSERT WEBLINK]. We now want to test our thinking to make sure our new approach meets the expectations of the people using pharmacy services and pharmacy professionals. Please let us know what you think about the proposal described in this document.

The consultation will run for 6 weeks and will close on Day Date Month 2016. During this time we welcome feedback from individuals and organisations. We will send this document to a range of stakeholder organisations, including professional representative bodies, employers, education and training providers, and patients’ representative bodies.

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

How to respond

You can respond to this consultation in a number of different ways. You can fill in the questionnaire at the end of this document or go to www.pharmacyregulation.org/get-involved/consultations/active-consultations and fill in an online version there.

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

• consultations@pharmacyregulation.org with the subject ‘Sampling CPD records for review’ or post it to us at:

• Sampling CPD records for review
  Consultation response
  Standards Team
  General Pharmaceutical Council
  25 Canada Square
  London
  E14 5LQ

Comments on the consultation process itself

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

• feedback@pharmacyregulation.org or post it to us at:

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

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

Once the consultation period ends, we will analyse the responses we receive. The council will receive the analysis at its meeting in December 2016, and will take the responses into account when considering the final changes we want to make to our current continuing professional development framework document.

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
Part 1: What we are changing and why

We are consulting on a change to paragraph 3.1 of our continuing professional development framework document. We are proposing a small change to the wording which will change our approach to checking the continuing professional development records of pharmacy professionals.

At the moment we normally check the continuing professional development records of all pharmacists and pharmacy technicians every five years. This means pharmacy professionals are called to submit their records of continuing professional development at least every five years but they are expected to be making records on a continuous basis.

We want to keep all of our approach the same (particularly the expectation that recording is done continuously) apart from the way in which we call records for review. We want to randomly select a minimum of 2.5% of pharmacy professionals (about 1 in 40) each year.

In developing this approach we took into account:

- what we heard through our review of our current approach which drew on the views of pharmacy professionals and the people who review their continuing professional development records
- what we learnt from reviewing the records of everyone on our professional registers over the last five years
- what we plan to do as we continue to develop our wider approach to assuring standards for pharmacy professionals are met throughout careers
- what other professional regulators do.

We think our proposed approach is more proportionate, effective, flexible, targeted and cost effective as well as in line with the expectations of the people who use pharmacy services and people working in pharmacy. However, we want to test this through this consultation.

We want to make this change because:

- 99.7% of pharmacy professionals over the last five years have met our continuing professional development requirements at the first attempt.
- Pharmacy professionals have told us that they do continuing professional development activities all the time, but tend to only record then when we ask to review them every five years. They also said that we needed to do things differently to more regular recording of activities.
- In future we plan to introduce more checks to make sure all pharmacy professionals have recorded their continuing professional development activities annually and instead focus the review process on giving better feedback to pharmacy professionals as individuals and as a group.
- Other regulators have a variety of approaches, but many use a sampling approach already and given what we know about how well pharmacy professionals do when we ask them to submit records it seems sensible and proportionate for us to adopt a similar approach.
- Our pilot study in 2016 shows us the new approach is more proportionate and effective.
Part 2: The change to the continuing professional development framework

Introduction

The only change we are proposing to the continuing professional development framework document is to paragraph 3.1 which currently reads:

“The GPhC may ask you to submit a CPD record for review at any time. Normally, this will happen every five years, but in some cases you may be asked to submit your CPD record for review more frequently than this, for example if you have been required previously to undertake remedial measures following a review of your CPD record or if you have a history of poor compliance with any of our standards.”

We want to change this paragraph to read:

“The GPhC may ask you to submit a CPD record for review at any time. Normally, we will call the CPD records of a random sample of registrants on an annual basis and, if you meet the GPhC’s CPD requirements you will be exempted from the next annual random selection. In some cases you may be asked to submit your CPD record for review more frequently than this, for example if you have been required previously to undertake remedial measures following a review of your CPD record or if you have a history of poor compliance with any of our standards.”

These changes mean:

- We can focus our attention and resources on pharmacy professionals who find it harder to meet our requirements at the first attempt. And we can learn more about the reasons why they find it harder.
- Pharmacy professionals are still expected to continuously do and record continuing professional development activities.
- We can use a sample to understand how well all pharmacy professionals are likely to be meeting out requirements and adapt our approach over time. For example, if more pharmacy professionals from a sample found it harder to meet requirements we might review a greater percentage in the following year.
- Pharmacy professionals may be called more frequently than every five years but, normally, no more often than every two years.
- Pharmacy professionals may be called less frequently than every five years.
- We will introduce further checks in future for all registrants to ensure CPD is recorded annually.
How we will use your responses

Following the consultation, we will publish a report summarising what we heard. We may quote parts of your response in that report or in other documents but if you respond as a private individual, we will not use your name unless you give consent for us to do so.

We may publish your response in full unless you tell us otherwise. If you want your response to remain confidential, you should explain why you believe the information you have given is confidential. However, we cannot guarantee that confidentiality can be maintained in all circumstances.

The GPhC may need to disclose information under access to information legislation (usually the Freedom of Information Act 2000).

If your response is covered by an automatic confidentiality disclaimer generated by your IT system, this will not in itself, be binding on the GPhC.

Any diversity monitoring information you give us will be used to review the effectiveness of our consultation process. It will not be part of a published response.
Consultation response form

Response to the consultation on standards for pharmacy professionals

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

☐ Please remove my name from my published response

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

Background questions

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

Are you responding:

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

Please tell us your:

name: ........................................................................................
address: ...................................................................................
email: ........................................................................................

Where do you live?

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

Are you responding as:

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

Section A1 – Pharmacy professionals

Are you:

☐ a pharmacist
☐ a pharmacy technician

Please choose the option below which best describes the area you mainly work in:

☐ community pharmacy
☐ hospital pharmacy
☐ primary care organisation
☐ pharmacy education and training
☐ pharmaceutical industry
☐ other (please give details)
Section B: Responding on behalf of an organisation

Please tell us your:

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

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

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

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

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

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

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

Is your organisation a:

- □ pharmacy organisation
- □ non-pharmacy organisation

Please choose the option below which best describes your organisation:

- □ body or organisation representing professionals
- □ body or organisation representing patients or the public
- □ body or organisation representing a trade or industry
- □ community pharmacy
- □ corporate multiple pharmacy
- □ independent pharmacy
- □ NHS organisation or group
- □ research, education or training organisation
- □ government department or organisation
- □ regulatory body
- □ other (please give details)
Consultation questions

We are particularly interested in your views on the following points, although we welcome your comments on any issues that you want to raise about the change to the continuing professional development framework.

Clarity
The changes we are making should be clear.

1. Is the amended paragraph clear?
   Yes / No

1a. What else, if anything, should be added to or removed from the paragraph?

Sampling
A sampling approach to requesting records for review on an annual basis should encourage more regular recording of continuing professional development activities. It will allow us to introduce more regular annual administrative checks over time and focus our attention on pharmacy professionals who may find it harder to meet our requirements.

2. Do you agree with our new approach of taking a sample of registrants to review their continuing professional development records?
   Yes / No

2a. If you do not agree with this approach, please explain why.
Equality analysis

We believe the focus of the standards on delivering person-centred care should have positive implications for people. We have not identified any implications that would discriminate against or unintentionally disadvantage any individuals or groups.

3. Are there any aspects of the changes we are proposing that could have a negative impact on patients, members of the public, pharmacists, pharmacy technicians, or any other groups?

Yes / No

4. Do you have any comments on the potential impact of the standards?
Equality monitoring

At the GPhC, we are committed to promoting equality, valuing diversity and being inclusive in all our work as a health professions regulator, and to making sure we meet our equality duties.

We want to make sure everyone has an opportunity to respond to our consultation on standards for pharmacy professionals. This equality monitoring form will provide us with useful information to check that this happens. You do not have to fill it in, and your answers here will not be linked to your consultation responses.

What is your ethnic group?

Please tick one box

White
- British
- Irish
- Other

Black or Black British
- Caribbean
- African
- Other

Mixed
- White and black Caribbean
- White and black African
- White and Asian
- other mixed (please give more information in the box below)

Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- other Asian (please give more information in the box below)
- Chinese or Chinese British
- Other ethnic group (please give more information in the box below)
What is your age?
Please tick one box

- under 20
- 20 – 29 years
- 30 – 39 years
- 40 – 49 years
- 50 – 59 years
- 60 + years

What is your religion?
Please tick one box

- None
- Christian
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Other (please give more information in the box below)

What is your gender?
Please tick one box

- male
- female
- other

Do you consider that you have a disability?
Please tick one box

- Yes
- No
Appendix A: collated consultation questions

1. Is the amended paragraph clear?

1a. What else, if anything should be added to or removed from the paragraph?

2. Do you agree with our new approach of taking a sample of registrants to review their continuing professional development records?

2a. If you do not agree with this approach, please explain why.
Public business

Standards for pharmacy professionals: consultation report

Purpose
To provide Council with an analysis of the standards for pharmacy professionals consultation and our proposed response to the comments received.

Recommendations
Council is asked to:

(i) note the analysis of the standards for pharmacy professionals consultation (Appendix 1)

(ii) discuss the key areas of feedback and our preliminary response and proposed changes to the standards, which will be presented to Council in October (section 3)

1. Introduction
1.1 The GPhC launched a consultation on draft standards for pharmacy professionals in April 2016. The consultation ran for 12 weeks and closed on 27 June 2016.

1.2 This consultation was the largest and most successful consultation the GPhC has held since coming into operation. A wide variety of communication channels were used to maximise participation in the consultation across a diverse range of stakeholder groups, and both general and targeted engagement were used to reach all potential audiences. Further information about our communication and engagement activities can be found in 16.09.C.08 Engagement and communications report.

1.3 A total of 1,295 responses were received from individuals and organisations through our online response form, email and by post. In addition, we discussed the standards in 35 events held across Great Britain, engaging with 378 patients and members of the public and 1,279 pharmacy professionals. The analysis of responses can be found at Appendix 1.
1.4 This paper sets out how we propose to respond to the feedback we received and the key changes we propose to make to the standards for pharmacy professionals.

2. Background

2.1 At its meeting in March 2016, Council considered and approved the standards for pharmacy professionals for consultation.

2.2 The standards build on and reflect the belief that it is the attitudes and behaviours of pharmacy professionals that make the most significant contributions to patient safety and the quality of care. Council has made a clear commitment to promoting a culture of patient-centred professionalism, and a core foundation of this is the standards for pharmacy professionals.

2.3 We have drafted the standards based on what we have heard from our engagement with pharmacy professionals and patients. Through our discussion paper ‘patient-centred professionalism in pharmacy’, the IPSOS MORI research we conducted in 2014, and engagement we carried out in late 2015 of provisional standards, we have heard about the importance of the areas that the nine new standards for pharmacy professionals cover. We believe they are necessary to deliver safe and effective care, and uphold trust and confidence in pharmacy.

2.4 The meaning of each of the standards is explained, and there are examples of the types of attitudes and behaviours that pharmacy professionals should demonstrate.

3. Discussions of consultation report

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

3.2 In summary:

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

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

iii. 95% of respondents thought the standards were clear

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

v. 90% of respondents agreed with our approach to religious and moral beliefs

vi. 12% of respondents believed that the standards could have a negative impact on patients, members of the public, pharmacists, pharmacy technicians, or any other groups
3.3 We have made a number of drafting changes in light of the responses we received. However, we do not propose any changes to the overall approach to the standards for pharmacy professionals.

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

i. standards were too generic, and detailed guidance is needed
ii. the application of the standards to non-patient facing roles
iii. religious and moral beliefs
iv. what the standards mean for students and trainees
v. the role of owners and superintendents, and workplace pressures
vi. clarity about the relationship between the standards, and FTP and CFTP

**Generic standards and the role of guidance**

3.5 Respondents (both individuals and those responding on behalf of organisations) said that they felt the standards were too generic, and whilst many did not go on to elaborate, those who did, mentioned that the standards did not account for the different expectations of different registrants, depending on varying levels of responsibility and expertise.

3.6 We also heard that the standards as drafted could apply to all healthcare professionals, with some viewing this as positive and others not. It was also said that there is nothing in the standards to recognise the specificity of pharmacy, namely medicine expertise. Many of the respondents thought that the contribution of pharmacy should be made more explicit.

3.7 We propose that no changes are made to the standards or the introduction to the standards in light of these comments. Raising the profile of pharmacy, and explaining the unique role of pharmacy professionals is not the purpose of the standards.

3.8 The standards are intended to set out the expectations placed on pharmacy professionals, and reflect what we have heard from patients and the public. They are also intended to apply to pharmacy professionals, wherever they practise. Therefore, specifically including reference to medicines and other specialist areas of practice could serve to undermine the applicability of the standards to all pharmacy professionals.

3.9 However, there were some areas in which respondents felt more detailed guidance would be helpful in applying the standards in practice, for example in relation to raising concerns. The requirement to raise concerns in standard 8 was recognised as important, but respondents said raising concerns can be difficult in practice, as concerns are not dealt with and at worst, a person raising concerns faces victimisation. There was strong support from pharmacy service users who took part in our events, firstly, for professionals
to raise concerns when there is a need and secondly, for professionals to be able to do that without fear of victimisation.

3.10 In addition, respondents suggested a number of additional areas where guidance would be beneficial. We intend to publish guidance over the course of 2017/18 in relation to:

i. confidentiality
ii. consent
iii. clear boundaries
iv. raising concerns
v. non-registered staff

3.11 It is important that we also recognise the role of other organisations, in particular professional leadership bodies, in providing support and guidance about how to meet the standards. And therefore, we should raise awareness of what we have heard about guidance with our stakeholders, so that they too can consider what support they need to provide.

**Non-patient facing roles**

3.12 Although the standards are intended to apply to all registrants regardless of setting, many felt that they were geared towards those who work in clinical, patient facing roles.

3.13 We have reviewed the introduction to make clearer how the standards apply to pharmacy professionals in non-patient facing roles. Additionally, we have reviewed the examples that support each standard and sought to make clearer how the standards apply.

3.14 As part of our communications and implementation plan we will consider additional ways of explaining how the standards apply to non-patient facing roles, in particular the standard about person-centred care.

**Religious and moral beliefs**

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

People receive safe and effective care when pharmacy professionals:

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

ii. tell relevant health professionals, employers or others if their own values or beliefs prevent them from providing care, and refer people to other providers
3.16 Most respondents (around 90%) agreed with the approach proposed. Some of the pharmacy organisations who commented on this matter welcomed the approach as it confirms current practice.

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

3.18 Reflecting on what we have heard, and further considering case law and the requirements of the Human Rights Act 1998, the European Convention on Human Rights and Equality Act 2010, we propose a change to the current approach.

3.19 We propose that a better balance should be struck between the needs of the person to receive safe and effective care and our desire to respect the beliefs and values held by individual pharmacy professionals.

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

3.21 We therefore propose changing the wording of the example given under Standard 1 to reflect para 3.20 above.

3.22 This is a complex area and we believe that additional guidance will be required. We propose, subject to Council’s discussions, to bring a paper to Council alongside the draft standards. This will set out our proposals for guidance development and consultation.

**What the standards mean for students and trainees**

3.23 In the consultation, we explained that we intend to ask all pharmacy students and trainee pharmacy technicians to meet the standards for pharmacy professionals, rather than having a separate student code of conduct.

3.24 The majority of respondents (93%) agreed with our approach to asking all pharmacy students and trainee pharmacy technicians to meet the same standards as registered professionals. However, some of those who provided further comments said they felt the standards are too strict for students who
have only just embarked on a journey to become a professional. Some noted that the current wording of the proposed standards was perhaps not directly applicable to students, for example, where the standards talk about providing care or demonstrating leadership.

3.25 Many agreed with students and trainees having to meet the standards in principle but requested clarification as to how the standards would be applied to students and trainees in practice. It was also noted that the introduction should make it clear these standards would also apply to students and trainees.

3.26 The feedback has highlighted an important distinction between the application of the standards to registrants (against which they are accountable) on the one hand, and the importance students familiarising themselves with the standards as part of their education and training in expectation of registration and accountability in due course. We therefore propose to make explicit that the standards for pharmacy professionals are relevant to all pharmacy students and trainees whilst they are on their journey towards registration and practice, but clarify that they are not applied in the same way; the standards should be viewed in the context of education and training and used as a tool to prepare students and trainees for registration as a pharmacy professional.

3.27 We will retain the current registration application processes, including declarations by prospective registrants, as to their fitness to practise.

The role of owners and superintendents, and workplace pressures

3.28 Individual respondents, often pharmacy professionals, expressed a view that the standards should also apply to owners and employers. We will need to clarify the legal framework and the different accountability mechanisms for owners and this will be explained in the introduction and will reference our standards for registered pharmacies.

3.29 In relation to organisational targets, some respondents mentioned that it could be difficult to maintain adherence to the standards in practice with employers reportedly putting pressure on pharmacy staff to achieve targets with increasing workloads overall and sometimes inadequate staffing levels. It was felt that organisations and employers should also be bound by the standards.

3.30 We will consider the feedback we received about owners, superintendent pharmacists and workplace pressures to inform our on-going work on modernising pharmacy regulation and our on-going programme of work on professionalism under pressure. We recognise that living up to high professional standards can be a personal challenge for individuals. Arguably, the fact that the context may be challenging is precisely why the public need
professionals to maintain standards, be able to manage difficult situations and competing priorities. It is equally important that there are appropriate systems in place, supported by existing legal protection and regulatory guidance, about raising concerns.

3.31 We already set standards for registered pharmacies which owners are accountable for meeting, and will take account of the feedback we have heard here when we review the standards for registered pharmacies.

**Standards and the relationship with FTP and CFTP**

3.32 We heard from some respondents that it wasn’t clear how the standards would be used to make decisions about an individual’s fitness to practise (FtP) or in the future continuing fitness to practise (CFTP) requirements.

3.33 As part of our work to implement the standards we will explain how the standards are used to underpin our regulatory work, including CFTP and FtP.

3.34 Explaining how our standards are used in FtP and CFTP will also be done through other resources and guidance that supports these two operational areas.

4. **Next steps**

4.1 The standards will be revised to reflect Council’s discussion, and Council will be asked to approve the standards for pharmacy professionals in October 2016. Council will also be asked to agree the date for standards to come into effect.

5. **Equality and diversity implications**

5.1 There are no equality and diversity implications for the consultation report itself.

5.2 We have however received considerable and useful feedback during the consultation which will require our equality analysis to be updated. This will also need to take into account Council’s discussion, including feedback on our proposed changes to the relevant section on religious and moral beliefs. A more detailed section, setting out further assessment of the equality and diversity implications will be presented to Council when they are asked to agree the standards for pharmacy professionals.

6. **Communications**

6.1 The consultation analysis will be published on our website.

6.2 A detailed communications plan will be developed to underpin the communication of new standards for pharmacy professionals, and the implementation of these. Further detail will be provided when Council is asked to agree the standards for pharmacy professionals.
7. Resource implications

7.1 There are no resource implications for publication of this report.

7.2 When Council is asked to agree the standards, the resource implications for communication and implementation of the standards will be set out in the paper.

7.3 This work continues to be delivered within our existing budget.

8. Risk implications

8.1 The standards underpin our regulatory work and it is important that they reflect Council’s commitment to promoting a culture of professionalism and the delivery of compassionate person centred care.

8.2 Confidence in the standards could be undermined if full consideration is not given to the responses and views we have heard. It is also important that we are able to communicate clearly why Council has made its decisions, as this will assist in communicating and explaining any changes to the standards.

Recommendations

Council is asked to:

(i) note the analysis of the standards for pharmacy professionals consultation (Appendix 1)

(ii) discuss the key areas of feedback and our preliminary response and proposed changes to the standards, which will be presented to Council in October (section 3)

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25 August 2016
Standards for pharmacy professionals – analysis of consultation responses

August 2016
Professional standards consultation – analysis of responses

This report presents the analysis of responses to the consultation on the GPhC’s Standards for pharmacy professionals.

The consultation was open for 13 weeks from 4 April to 27 June 2016. We received 1,295 written responses to the consultation. In addition we discussed the standards in 35 events together with pharmacy professionals, patients and members of the public, engaging with 378 patients and members of the public and 1,279 pharmacy professionals through events held across Great Britain.
Written responses

Of those who submitted a written response, 104 were organisations and 1,191 individuals, most of which were submitted using the online questionnaire. The vast majority of individual respondents (1,123, around 95 per cent) identified themselves as a pharmacy professional. Around 2 per cent (25) indicated they were a member of the public. Just above 1 per cent (14) said they were a student and just under 1 per cent (7) said they were a pre-registration trainee. Eleven respondents described themselves as “other”, including academics, members of GPhC’s committees, and a retired pharmacist. The remainder of individual respondents did not indicate the capacity in which they were responding. Around two-thirds (750) of those describing themselves as “pharmacy professionals” were pharmacists, while around a third (373) were pharmacy technicians. The full list of organisations responding to the consultation can be found in appendix A.

Engagement events

Engagement events were also a critical part of the consultation activities and were particularly useful in reaching those groups who were less likely to respond to the consultation via the online form, including individual patients and members of the public and pharmacy students. We took part in 35 events across Great Britain, with 15 of these events organised by the GPhC and 20 events organised by other organisations. We also held a number of individual meetings with key stakeholders, including organisations representing other health professionals and health and social care providers, to hear their views on the consultation. A full list of the events and meetings held during the consultation is included in appendix B.

Our events were attended by a variety of pharmacy users – patients, carers/parents, and those who had long term conditions, as well as those who collect a prescription now and again. They used a variety of pharmacies, independents, supermarket pharmacies or pharmacies on the high street. We heard of many kinds of experiences of using pharmacy services, most positive but some that were not. Overall, pharmacies were trusted and valued but people were not always aware of all the different services available.

People found the standards easy to understand and participants at our stakeholder events agreed with the standards in general. They said the standards reflected what they would expect from pharmacy professionals, or other health professionals.
Analysis

This report follows the structure of the formal consultation document and questionnaire.

The great majority of responses were submitted through SmartSurvey using the formal consultation questionnaire. Responses to the yes/no questions have been reported giving both the numbers of responses as well as percentages. Responses to the open questions were analysed using an iterative coding process, in which themes emerging from the responses were identified. The main themes or topics are presented in this report in the narrative under each relevant question. The thematic coding frame also informed the analysis of responses that were submitted by email or post, and these too are reported in the narrative. Finally, key findings from engagement events with both pharmacy users as well as students and professionals are also incorporated in the report.

It should be noted that whilst there were typically some 1,200 responses to the quantitative, yes/no questions, the number of responses were much lower to the qualitative, open questions, usually around a few hundred.

This report summarises the key topics that emerged in the consultation responses. All issues raised in these contributions have been fully taken into account and, where applicable, incorporated into this report.

What we heard

Overall, the standards were received very positively throughout. However, as expected, many suggestions for further improvements or requests for further clarification were submitted as part of the consultation responses. The following section presents key issues raised under each section of the consultation and follows the order of the consultation questionnaire, with views expressed in the consultation engagement events incorporated in the analysis.
Context

1. Is the introduction clear?

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1a. What else, if anything, should be added to or removed from the introduction?

The introduction to the standards was found overwhelmingly clear by almost all respondents but number of comments, suggestions for clarification and improvement were also given.

Overall, the focus on person centred care was welcomed although a small number of professionals responding felt ‘patient centred’ care would be more appropriate. Interestingly, the term person centred was discussed in some of the public engagement events, and ‘person’ rather than ‘patient’ centred was preferred.

Indeed there were some who wanted clarification as to what was meant by person centred care within the context of GPhC standards, as the concept can take different meanings in different settings. Similarly, some noted that professionalism is not just about attitudes and behaviours but also knowledge, competency and skills.

It was also said that there is nothing in the standards to recognise the specificity of pharmacy, namely medicine expertise, and that the standards could apply equally to any healthcare professionals. Many of the respondents thought that the contribution of pharmacy should be made more explicit.

Although the standards are intended to apply to all registrants regardless of setting, many felt that they were geared towards those who work in clinical, patient facing roles. It was also frequently mentioned that if the standards are to apply to students too, then this should be made explicit throughout. In terms of the standards being applicable ‘at all times’, a few respondents suggested that this required clarification. This was also something noted in the public engagement events.

A few of the respondents, both organisations and individuals, said they felt the standards were too generic, and whilst many didn’t go on to elaborate, those who did, mentioned that the standards didn’t account for how there would be different expectations of different registrants, depending on varying levels of responsibility and expertise.

Individual respondents, often pharmacy professionals, maintained that the standards should also apply to owners and employers, and this should be explained in the introduction.
In reference to the introduction stating that pharmacy professionals should follow ‘relevant laws’ there were a small number of calls (from organisations) to be clearer on the relationship of laws, standards, guidance and even SOPs and how professional judgment was to be applied within the parameters set by these. Indeed some said SOPs should be explicitly mentioned in the standards so that it is clear to pharmacy professionals that these were still to be followed.

Also, more information was requested about how the standards will be implemented and enforced, by what mechanisms and what role the regulator will have.

Finally, some respondents to the consultation asked about the rationale for the new standards, specifically why it was felt nine were needed instead of the seven in ‘The standards of conduct, ethics and practice’. There were also requests that differences between the existing and new standards should be made more explicit, detailing what has changed, and why. A number of different practical comments were made, for example sections in existing standards that respondents wished to retain as these were felt to capture the essence better than the new wording.
Students

2. We also intend to ask all pharmacist and pharmacy technician students to meet the standards for pharmacy professionals, rather than having a separate student code of conduct. Do you agree with this approach?

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2a. If you do not agree with this proposal, please explain why.

The majority of respondents (93%) agreed with our approach to asking all pharmacist and pharmacy technician students to meet the same standards as registered professionals. However, some of those who provided further comments said they felt the standards are too strict for students who have only just embarked on a journey to become a professional. Some noted that the current wording of the proposed standards was perhaps not directly applicable to students, for example, where the standards talk about providing care or demonstrating leadership.

Many agreed with students having to meet the standards in principle but requested clarification as to how the standards would be applied to students in practice. It was also noted that the introduction should make it clear these standards would also apply to students and trainees.
The nine standards for pharmacy professionals

3. Are the standards clear?

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3a. What, if anything, is unclear?

4. Are there any standards you do not agree with? If so, please explain.

5. Are there any other standards that you think are missing? If so, please explain.

While, again, most respondents (95%) found the nine standards clear, feedback was given to clarify points or to provide suggestions for addition.

While pharmacy users who took part in our engagement events found the standards clear, reflecting what they would expect from pharmacy professionals, many of the professionals responding said the standards were too generic and said further examples, such as case studies of good and poor practice would be helpful. Professionals responding thought the standards were written in such a way that they were not applicable to all, and that mostly the focus was on roles that have direct contact with patients and the public.

There were several mentions here about standard 9 on demonstrating effective leadership. On the whole, the feedback given on this particular point suggests that the term leadership was somewhat unclear, what it would mean in this context and how this standard should be applied in practice. For example, respondents were not sure what this would mean for different groups such as students, or professionals with different levels of seniority and responsibility. Similar observations were made in the public engagement events.

Standard 5 sets out that registrants should not let organisational targets and goals influence the care they provide, and on the whole this was welcomed. However, some respondents mentioned that it could be difficult to maintain this in practice with employers reportedly putting pressure on pharmacy staff to achieve targets with increasing workloads overall and sometimes inadequate staffing levels. It was felt that organisations and employers should also be bound by the standards.

On a related note, the requirement to raise concerns in standard 8 again was recognised as important, but respondents said raising concerns can be difficult in practice, as concerns are not dealt with and at worst, a person raising concerns faces victimisation. There was strong support from pharmacy service users taking part in our events, firstly, for professionals to raise concerns when there is a need and secondly, for professionals to be able to do that without fear of victimisation. Some of the professional respondents called for owners and
employers to also abide by the standards. A few comments were made about the requirement to ‘say sorry’ - it was felt clarification would be beneficial to make it clear that this would not necessarily be the same as admitting liability.

Standard 3 on communication was felt to be one of the most important ones by the pharmacy users attending our stakeholder events, as good communication with patients was felt to be particularly important: such as getting advice on how to take medication correctly and having clear labels. Also, the importance of overcoming language barriers was mentioned in this context as something that should potentially be covered by the standards. Some professional respondents mentioned that the requirement for English language skills should be stated explicitly. The importance of good communication with other health professionals was also mentioned.

In the context of providing patient centred care, there were also a few responses that asked for a recognition of limited public resources.

Patients and carers felt that standard 7 on privacy was important. There was a broad agreement that privacy should be maintained. However, there were also mentions that this would not necessarily happen with interactions often taking place by the counter with other pharmacy users present - giving personal information to confirm a prescription was mentioned as an example. Many didn’t know about private consultation rooms, or said there weren’t any in the pharmacies that they used.
Applying the standards

6. Do you think the section ‘applying the standards’ is useful in helping you to understand the standards?

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7. Do you think the ‘applying the standards’ sections are clear and easy to understand?

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8. What is unclear? Please say which standard or standards you mean, and explain why you think there is a problem with the ‘applying the standard’ section.

9. Are there any examples that are missing in the sections ‘applying the standards’?

It was again noted in this section that the standards could better reflect different types of pharmacy practice, including practice of those who do not work directly with patients or in clinical settings. Again, the standards were also said to be too generic, and there were requests for more examples about both good and poor practice, and case studies to support the adoption of standards.

Respondents also requested support in navigating the workplace pressures reported in pharmacy. Particularly examples around professional judgment and balancing different legal requirements, different guidance, and the standards would be found helpful. Organisations on the other hand requested recognition of the relationship between laws, standards and guidance or SOPs, and that professional judgment needs to operate within the parameters set by these.
Values & personal beliefs

10. The new standards and their explanations make clear that a pharmacy professional’s personal values and beliefs must be balanced with the care they give people who use pharmacy services. Do you agree with our approach?

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11. If you do not agree with this approach, please explain why.

12. Do you have any other comments?

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

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

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

There was also a view expressed that referring to another service provider in itself could be against a pharmacy professional’s values and beliefs. Furthermore, it was said that refusing to provide a service was likely to have a detrimental impact on the pharmacy professional as it would be likely affect their employment opportunities.
Equality analysis

13. Are there any aspects of the standards that could have a negative impact on patients, members of the public, pharmacists, pharmacy technicians, or any other groups?

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14. Do you have any comments on the potential impact of the standards?

It was felt that the standards reflect what pharmacists are already doing or should be doing; this was the view of both professionals and pharmacy users. A few areas that could potentially impact different groups negatively were identified. Views were expressed that the approach proposed in the consultation document to pharmacy professional’s personal beliefs and values could have a negative impact on patients.

Another issue, raised here as well as under some of the other questions, was around how to negotiate any conflict between the standards and expectations from employers. This was felt to have a negative impact on pharmacy professionals.
Supporting pharmacy practice

15. We plan to review and update our guidance in the following areas:
• Raising concerns: explains how pharmacy professionals should raise concerns that they have
• Consent: explains the principles of consent
• Confidentiality: explains the steps to take to protect the confidential information obtained in the course of professional practice
• Maintaining clear sexual boundaries: explains the importance of maintaining clear sexual boundaries, and explains the responsibilities pharmacy professionals have
• Balancing personal beliefs and the care of patients: what pharmacy professionals need to do if their religious or moral beliefs affect the provision of pharmacy services to patients and the public

Do you agree with the areas we have identified?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1,200</td>
<td>97.24%</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>2.76%</td>
</tr>
<tr>
<td>Total</td>
<td>1,234</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

16. What other support, if any, do you think pharmacy professionals need?

The consultation questionnaire finished with asking about additional support needs. Several suggestions were made, these were the most frequently mentioned:

Support on dealing with workplace pressures discussed elsewhere in this consultation report – working conditions, staffing, pay, bullying in the workplace – including the management of conflicts between business requirements and patient needs. As well as support in relation to using one’s professional judgment – how to balance the legal, ethical and professional obligations. In the same vein, support was requested with issues around raising concerns – and having clarity on a ‘route’ for raising concerns and also support for whistle-blowers without fear of victimisation. Some felt it necessary for pharmacy owners and managers to also have standards and be held to account on these workplace issues.

It was also said that for a successful roll out of the standards there should be training and training materials available. More generally, real-life examples of good or poor practice to support the standards; and also links to relevant guidelines were requested. And on a more ongoing basis support with learning, training or development – including protected learning time, CPD days, specialised training (e.g. management, legislation, dementia awareness training)
Also, support on issues of data protection and confidentiality, how to use and access patient data, summary care records, and taking advantage of IT and technology underpinning these, was frequently mentioned.

Other areas or methods of support mentioned were:

- A free and confidential helpline for advice and support for pharmacy professionals
- The importance of support groups, peer reviews, or a regular forum to discuss issues and share concerns
- Union-type support regarding pharmacists’ pay, contracts and funding
- Guidance for students and how standards apply to them

Specific areas where further support and guidance would be beneficial included:

- Safeguarding
- Communication
- Leadership
- Social media
- Consent
Appendix A: Organisations responding

Aneurin Bevan Community Health Council
Association of Pharmacy Technicians UK
Association of Teaching Hospital Pharmacists
British Medical Association
Bat & Ball Pharmacy
Betsi Cadwaladr University Local Health Board
BLM
Boots Pharmacists' Association
Buchanhaven Pharmacy Ltd.
Bupa Home Healthcare
Buttercups Training Ltd
Cardiff School of Pharmacy & Pharmaceutical Sciences
Carers Trust Scotland
Carters Chemist
Christians in Pharmacy (CIP) network
Clifton Pharmacy
Community Pharmacy Cheshire and Wirral, Local Pharmaceutical Committee
Community Pharmacy Scotland
Community Pharmacy Wales
Cornwall and Isles of Scilly LPC
Darlington's Peoples Party
Dorset LPC
East Sussex plc
ENH Pharma Ltd
Epilepsy Action
Forum for Older People
Gender Identity Research and Education Society (GIRES)
General Medical Council
Guys & St Thomas' NHS Foundation Trust
Guild of Healthcare pharmacists
Hadlow Pharmacy
Hampshire LPC
Health Education England - Kent, Surrey, Sussex
Health Education England - London & South East
Health and Care Professions Council
Healthcare Improvement Scotland
Healthwatch Bedford Borough
Healthwatch Bromley
Healthwatch Cheshire East
Healthwatch Dudley
Healthwatch Lincolnshire
Healthwatch Rutland
Healthwatch Southend
Healthwatch Torbay
Humber Local Pharmaceutical Committee
International Longevity Centre - UK
King's College London
Kingston University
L. Rowland and Co (Retail) Ltd t/a Rowlands Pharmacy
Leeds Community Healthcare NHS Trust
Leicester School of Pharmacy, De Montfort University
Livewell Southwest Pharmacy Services
London Chief Pharmacists Network
Manchester Pharmacy School
Medicines Management Team, Bromley Clinical Commissioning Group
Mildcare Ltd
National Care Forum
National Pharmacy Association
NHS Ayrshire and Arran
NHS Education for Scotland
NHS England
NHS Greater Glasgow & Clyde
Patient centred & equality group: NHS Greater Glasgow & Clyde Addiction Service
NHS Scotland Directors of Pharmacy group
NHS Specialist Pharmacy Service
NHS Stockport CCG
North East London Local Pharmaceutical Committee
Nottingham University Hospitals NHS Trust (Pharmacy Education & Training Team)
Numark
Patients Association
Penrith health centre pharmacy
Pharmaceutical advisers group, Wandsworth CCG
Pharmacy Defence Association
Pharmacy Schools Council
Pharmacy Voice
Robert Gordon University
Royal College of Nursing
Royal Pharmaceutical Society
Solicitors Regulation Authority
School of Pharmacy, Keele University
School of Pharmacy, The University of Nottingham
School of Pharmacy, University of Bradford
Scientia Skills
Scottish Specialist Pharmacists in Substance Misuse
Secular Medical Forum
Severn Chemist
South Essex Partnership University NHS Foundation Trust
South Staffordshire Local Pharmacy Committee
The Care Forum
The Education and Training Operational Sub-Group of the All Wales Chief Pharmacist Committee
The National LGB&T Partnership
The National Society for Epilepsy
UK Paediatric Chief Pharmacists
University Hospital Southampton NHS Foundation Trust
University of Brighton
University of Central Lancashire
University of Hertfordshire
University of Huddersfield
University of Reading
University of Strathclyde
Vantage Pharmacy
Well
Willows Pharmacy
Workforce Education and Development Services
Appendix B: Engagement events

Events: consultation on standards for pharmacy professionals

GPhC events

- Workshop with MPharm students, Glasgow, 20 April 2016
- Focus Group with patients and public, Glasgow, 20 April 2016
- Stakeholder event with pharmacy professionals, Glasgow, 20 April 2016
- Focus Group with patients and the public, London, 26 April 2016
- Focus Group with patients and the public, Cardiff, 27 April 2016
- Stakeholder event with pharmacy professionals, Cardiff, 27 April 2016
- Workshop with MPharm students, Manchester, 10 May 2016
- Focus Group with patients and the public, Manchester, 10 May 2016
- Stakeholder event with pharmacy professionals, Manchester, 10 May 2016
- Stakeholder event with pharmacy professionals, London, 17 May 2016
- Focus group with patient and public organisations policy leads, 19 May 2016
- Focus group with Greater London Older People's Forum, 24 May 2016
- Focus group with Whitworth Chemist patient participation group, 26 May 2016
- Focus group with Tower Hamlets parents and carers’ forum, 15 June 2016
- Focus group with Alliance, 23 June 2016

External events

- Presentation to Sandwell Local Pharmaceutical Committee, 16 March 2016
- Presentation to pharmacy technician students at Edinburgh College, 16 March 2016
- Presentation to Pharmacy School Council, 17 March 2016
- Presentation to APTUK National Officers, 19 March 2016
- Presentation at British Pharmaceutical Students Association Annual Conference, 22 March 2016
- Presentation at WCPPE and RPS joint event, 11 April 2016
- Workshop with APTUK London branch, 13 April 2016
• Presentation at Pharmacy Voice event, 14 April 2016
• Presentation to University of Brighton, 14 April 2016
• Presentation at Boots Pharmacists Association AGM, 19 April 2016
• Presentation at Clinical Pharmacy Congress, 22-23 April 2016
• Presentation to Pharmacy Law and Ethics Association, 4 May 2016
• Presentation to Community Pharmacy Scotland, 11 May 2016
• Workshop with Diverse Cymru, 17 May 2016
• Update to Northern Chief Pharmacists’ annual meeting, 19 May 2016
• Presentation at APTUK Annual Conference, 10-11 June 2016
• Presentation to RPS Black Country, 14 June 2016
• Presentation to East Sussex Local Pharmaceutical Committee, 16 June 2016
• Presentation to National Pharmacy Association, 21 June 2016
• Stand at National Young Carers Festival, 25 June 2016
Public business

Chief Executive and Registrar’s report

Purpose
To keep Council abreast of significant recent developments.

Recommendations
Council is asked to note the Chief Executive and Registrar’s report.

1. Recent meetings
1.1 A list of recent meetings held or attended by the Chair, the Chief Executive and senior staff is now included in the quarterly engagement and communications report to Council.

2. New Chief Pharmaceutical Officer for Wales
2.1 The Welsh Government has announced that Andrew Evans has been appointed Wales’ new Chief Pharmaceutical Officer.
2.2 Andrew is a public health specialist and was most recently Principal Pharmacist at Public Health Wales, a post he held since 2012. He has been acting Chief Pharmaceutical Officer since January 2016, following the retirement of Roger Walker.

3. Ministerial appointments
3.1 The Prime Minister has announced the following appointments:

Jeremy Hunt remains as Secretary of State for Health.

Philip Dunne – Minister of State for Health. The minister leads on the following policy areas:
- hospital care
- NHS performance and operations
- NHS workforce
- patient safety
- healthcare regulation
- maternity care

**David Mowatt** - Parliamentary Under Secretary of State for Community Health and Care. The minister leads on the following policy areas:
- adult social care, carers
- community services
- cancer
- dementia
- learning disabilities
- all elements of primary care – including pharmacy

**Nicola Blackwood** - Parliamentary Under Secretary of State for Public Health and Innovation. The minister leads on the following policy areas:
- public health
- health protection
- technology
- innovation
- data

**Jo Johnson** remains as the minister responsible for higher education.

4. June 2016 Registration Assessment

4.1 There were 2804 candidates who sat the GPhC’s Registration Assessment on 29 June 2016, with 2672 candidates who passed the exam which is an overall pass rate of 95%. There were 2614 candidates who sat the assessment for the first time, 102 for the second time and 88 for the third time.

4.2 A list of the successful candidates has been published on the [GPhC website](https://www.gphc.org.uk).

5. Demonstrating professionalism online

5.1 The GPhC recently published a short document for registrants on [demonstrating professionalism online](https://www.gphc.org.uk), setting out what is expected of pharmacists and pharmacy technicians when using social media and other online channels of communication and providing links to other sources of guidance and advice.
Recommendations
Council is asked to note the Chief Executive and Registrar's report.

Duncan Rudkin, Chief Executive and Registrar
General Pharmaceutical Council
duncan.rudkin@pharmacyregulation.org
020 3713 7811
17 August 2016
Council meeting 08 September 2016 16.09.C.08

Public business

Engagement and communications report

Purpose
To keep Council abreast of engagement and communications with stakeholders via a quarterly report.

Recommendations
Council is asked to note this paper.

1. Introduction
1.1 This report outlines key communications and engagement activities in the last quarter and highlights upcoming events and activities.

2. Consultation on standards for pharmacy professionals
2.1 The consultation on new standards for pharmacy professionals ran from April to June 2016 and was the largest and most successful consultation the GPhC has held since coming into operation.

2.2 We received 1295 written responses to the consultation and engaged with 378 patients and members of the public and 1279 pharmacy professionals through events held across Great Britain.

2.3 We used a wide variety of communications channels to maximise participation in the consultation across a diverse range of stakeholder groups and used both general and targeted engagement to reach all potential audiences.

2.4 Digital channels were central to the campaign and our email campaigns were particularly successful. Over 500 consultation responses were received within 24 hours of an email being sent to all registrants encouraging them to respond. Targeted email campaigns were also effectively used to reach groups representing patients and the public and other health professionals, leading to many of these groups promoting the consultation to members and submitting responses.
2.5 Social media was also extensively used to promote the consultation. Social media posts and sponsored targeted engagement through Facebook were used throughout the consultation to generate discussion and interest in the consultation.

2.6 Our social media posts generated over 800,000 impressions and over 5000 visits to the consultation homepage. Almost 300 pharmacy professionals joined a webinar organised by the GPhC and a further 36 pharmacy professionals participated in a Twitter chat held with WePharmacists. Traditional media outlets were also used to promote the consultation, with all of the main pharmacy trade titles writing articles about the consultation following interviews with the Chief Executive.

2.7 Engagement events were also a critical part of the consultation activities and were particularly useful in reaching those groups who were less likely to respond to the consultation via the online form, including individual patients and the public and pharmacy students. We took part in 36 events across Great Britain, with 13 of these events organised by the GPhC and 23 events organised by other organisations. We also held a number of individual meetings with key stakeholders, including organisations representing other health professionals and health and social care providers, to hear their views on the consultation. A full list of the events and meetings held during the consultation is included in Appendix 1.

2.8 A key focus during the consultation was encouraging participation from groups representing people with protected characteristics under the Equality Act 2010 and groups representing other people who may have particular needs or face particular challenges when accessing pharmacy services. A range of channels were used to engage with these groups, including targeted approaches via email and telephone and through events, including with young carers, people with protected characteristics living in Wales, older people and parents.

3. **Registration assessment 2016**

3.1 The first sitting of the registration assessment under the new process took place on 30 June 2016. Extensive engagement and communications with candidates, tutors, training providers, pre-registration training leads and schools of pharmacy took place in the run-up to the assessment to ensure candidates understood what to expect from the assessment. This included holding a webinar, producing videos and other online resources to explain the changes for trainees and those supporting them, and speaking at a number of events to explain the new assessment and reasons for the changes.

3.2 All candidates sitting the registration assessment were asked to complete a survey about their experiences. Candidates were asked how they would rate
the resources and information provided overall, with 85% saying they would rate these resources as very good or fairly good.

3.3 The pass list was published on 29 July and a press release was issued to the media to highlight the results and the changes to this assessment. The media coverage has highlighted the relatively high pass rate, but has been neutral or positive in tone overall.

3.4 The President of the British Pharmaceutical Students Association welcomed the resources provided to pre-registration trainees ahead of the first sitting of the new assessment, telling the Pharmaceutical Journal: “Through the use of webinars and the implementation of the framework, candidates have been more thoroughly informed of the format of questions and the content of the assessment”.

4. Annual report 2015/16

4.1 The GPhC’s annual report 2015/16 was laid before the UK and Scottish Parliaments in June 2016 and shared with key stakeholders via email.

5. Publication of Demonstrating professionalism online

5.1 New guidance for registrants on using social media was published on our website in July 2016 and promoted via our social media platforms and through Regulate, our bi-monthly bulletin.

6. DH consultation events

6.1 In July GPhC colleagues attended a series of pre-consultation engagement events led by the Department of Health on the reform of UK health professional regulation. The events were attended by a range of stakeholders representing policy makers, regulators, registrants, employers and patient organisations. Discussions centred on the purpose, agility and cost effectiveness of regulation and the feedback from the events will inform future policy development in this area. Given recent changes to the political landscape, no indication was given at the events as to whether legislative change is still anticipated in this Parliament.

7. Recent meetings

7.1 Listed in Appendix 2 is a non-exhaustive selection of significant meetings held during the two months since the last Council meeting.

7.2 Council members are reminded to liaise with the office before accepting external invitations to speak on behalf of the GPhC in order to minimise overlap and to ensure that they have the most up-to-date supporting material.
8. **Upcoming events and activities**

Please contact Laura Oakley, Stakeholder Engagement Manager, if you would like to attend any of these events:

8.1 **Pharmacy Show, 25-26 September**: Duncan Rudkin will address the conference on key developments in pharmacy regulation. The GPhC will also have a stand at the show.

8.2 **GPhC seminar on understanding issues relating to ethnicity and academic performance, 10 October**: Nigel Clarke will chair this event, which will bring together a wide range of stakeholders with an interest in pharmacy education and training to discuss key issues relating to ethnicity and academic performance within pharmacy education and training. Professor Uduak Archibong, Professor of Diversity at the University of Bradford, will give the keynote address at the seminar. Delegates will have the opportunity to discuss the findings of the research commissioned by the GPhC and what actions should be taken in response.

8.3 **GPhC seminar on professionalism under pressure, 18 October**: Professor Nairn Wilson, Past President of the British Dental Association, will chair this event, which will bring together a wide range of stakeholders to build a greater understanding of issues relating to workplace pressures within pharmacy and in other parts of healthcare, and to discuss how these issues could be addressed by individuals and organisations across the sector. Professor Michael West, Head of Thought Leadership at The King’s Fund and an expert on creating workplace cultures to support high-quality care, has agreed to give the key note speech at the seminar.

9. **Equality and diversity implications**

9.1 We are working to embed equality, diversity and inclusion in all of our communications and engagement activities. A key commitment is to effectively engage with a diverse range of audiences and to make sure our events and other engagement activities are as accessible and inclusive as possible.

9.2 As part of this commitment, our Stakeholder Engagement Manager has recently participated in training courses run by the Business Disability Forum on organising accessible meetings and events and producing accessible communications and we are now applying the learnings from these training courses to our activities.

9.3 We produced an EasyRead version of the consultation document for the proposed standards for pharmacy professionals, which was welcomed by groups representing people with learning disabilities.
Recommendations

Council is asked to note this paper.

Rachael Oliver, Head of Communications  
General Pharmaceutical Council  
rachael.oliver@pharmacyregulation.org  
Tel 020 3713 7961  
25 August 2016
Appendix 1

Events and meetings: consultation on standards for pharmacy professionals

GPhC events:

- Workshop with MPharm students, Glasgow, 20 April 2016
- Focus Group with patients and public, Glasgow, 20 April 2016
- Stakeholder event with pharmacy professionals, Glasgow, 20 April 2016
- Focus Group with patients and the public, London, 26 April 2016
- Focus Group with patients and the public, Cardiff, 27 April 2016
- Stakeholder event with pharmacy professionals, Cardiff, 27 April 2016
- Workshop with MPharm students, Manchester, 10 May 2016
- Focus Group with patients and the public, Manchester, 10 May 2016
- Stakeholder event with pharmacy professionals, Manchester, 10 May 2016
- Stakeholder event with pharmacy professionals, London, 17 May 2016
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- Focus group with Greater London Older People's Forum, 24 May 2016
- Focus group with Whitworth Chemist patient participation group, 26 May 2016
- Focus group with Tower Hamlets parents and carers’ forum, 15 June 2016
- Focus group with Alliance, 23 June 2016

External events and meetings:

- Presentation to Sandwell Local Pharmaceutical Committee, 16 March 2016
- Presentation to pharmacy technician students at Edinburgh College, 16 March 2016
- Presentation to Pharmacy School Council, 17 March 2016
- Presentation to APTUK National Officers, 19 March 2016
- Presentation at British Pharmaceutical Students Association Annual Conference, 22 March 2016
• Presentation at WCPPE and RPS joint event, 11 April 2016
• Workshop with APTUK London branch, 13 April 2016
• Presentation at Pharmacy Voice event, 14 April 2016
• Presentation to University of Brighton, 14 April 2016
• Presentation at Boots Pharmacists Association AGM, 19 April 2016
• Presentation at Clinical Pharmacy Congress, 22-23 April 2016
• Presentation to Pharmacy Law and Ethics Association, 4 May 2016
• Presentation to Community Pharmacy Scotland, 11 May 2016
• Workshop with Diverse Cymru, 17 May 2016
• Update to Northern Chief Pharmacists’ annual meeting, 19 May 2016
• Meeting with NHS Clinical Commissioners, 27 May 2016
• Meeting with Royal College of Nursing, 1 June 2016
• Presentation at APTUK Annual Conference, 10-11 June 2016
• Presentation to RPS Black Country, 14 June 2016
• Meeting with British Humanist Association, 14 June 2016
• Presentation to East Sussex Local Pharmaceutical Committee, 16 June 2016
• Meeting with National Care Forum, 16 June 2016
• Meeting with Care Forum Wales, 20 June 2016
• Presentation to National Pharmacy Association, 21 June 2016
• Stand at National Young Carers Festival, 25 June 2016
Appendix 2

List of meetings

Listed below is a non-exhaustive selection of significant meetings held during the two months since the last Chief Executive and Registrar’s report to Council.

Initials are as follows: Nigel Clarke (NC), Duncan Rudkin (DR), Hugh Simpson (HS), Claire Bryce-Smith (CBS):

Chair (Nigel Clarke):

- Association of Pharmacy Technicians UK Conference – speaking
- Meeting with Lord Hunt (with DR)
- Care Conversation Event: The Importance of Regulation – speaking
- Meeting with Chair, Board of Assessors (with DR and HS)
- Rebalancing Programme Board meeting (with DR)
- Meeting with Chair and Chief Executive, Pharmacy Voice (with DR)
- Royal Pharmaceutical Society Conference – speaking

Staff:

- Meeting with Lord Hunt (DR with NC)
- Meeting with Lead Pharmacist, Ministry of Defence (DR)
- Meeting with Chief Pharmaceutical Officer Wales (DR)
- Royal Pharmaceutical Society Welsh Board meeting (DR)
- Meeting with Chair, Board of Assessors (DR, HS with NC)
- Public Policy Exchange Symposium: Overhauling the NHS Complaints System: Reducing Complexity to Improve Patient Experience and Safety (CBS)
- Meeting with Registrar, Australian Pharmacy Council (HS)
- Chief Executives Legislation Group meeting (DR & HS)
- Care Quality Commission External Advisory Group for Medicines Optimisation Meeting (CBS)
- Meeting with Chief Executive, Professional Standards Authority (DR)
- Rebalancing Programme Board meeting (DR with NC)
- Regulators FIP Directors Meeting (CBS)
- Pharmacy Professional Advisory Group Meeting (CBS)
- Solicitors Regulation Authority conference: Trust and the market: rethinking regulation – panel discussion (HS)
• Meeting with Director of Professional Development & Support, Royal Pharmaceutical Society (HS)
• Chief Executives Steering Group meeting (DR)
• Regulators Liaison Group meeting (DR)
• Meeting with Chief Pharmaceutical Officer Scotland (DR)
• Meeting with Director of Workforce, Department of Health (DR)
• Meeting with Chair and Chief Executive, Pharmacy Voice (DR with NC)
• Health and Social Care Regulators Forum Meeting (DR)
• Directors of Scotland meeting (CBS)
• Meeting with Professor of Pharmacy Practice, University of Toronto (HS)
• Meeting with Chief Pharmaceutical Officer, NHS England (DR)
Council meeting 8 September 2016  16.09.C.09

Public business

Performance monitoring report to end June 2016

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

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

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

2. Fitness to Practise (FtP)
2.1 Across the quarter, a greater number of cases were closed than the number of concerns received, and the number of cases closed increased by 23% from the previous quarter.
2.2 The open caseload age profile and the average numbers of cases closed at IC and FtPC have remained stable across this quarter.
2.3 Four appeals were concluded successfully.

3. Inspections
3.1 The number of routine inspections exceeded 900 for the second quarter in succession, which reflects achievement in April of the second highest number of inspections since the new approach began.
3.2 Pharmacies that have not been inspected for 48 months or more continue to be targeted, focusing on the oldest in each inspector's allocated region. The
aim is to reach and maintain a position whereby all pharmacies are inspected within four and a half years.

4. **Human Resources**

4.1 Sickness figures are inflated by the inclusion of long-term sick data for a small number of staff. Figures may increase marginally as HR continues to develop its absence monitoring systems.

4.2 Staff turnover is 12.99%. HR continues to put into place a number of improvements to increase retention levels including a corporate induction and training programme, succession planning and better alignment of recruitment to role.

5. **Finance**

5.1 Current liabilities of £14.3m include £12.5m deferred income (fees and working capital grants) received but not yet credited to the profit and loss account.

5.2 There is a year to date surplus of £0.2m, as opposed to the budgeted deficit of £0.4m, due to a combination of cost savings and re-phasing. The expected result for the year is a £296k deficit – a saving of £709k compared with the original budget, which amounts to a 2% saving in expenditure overall.

6. **Equality and diversity implications**

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

7. **Communications**

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

8. **Resource implications**

8.1 Resource implications are addressed within the report.
9. **Risk implications**

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

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

10. **Monitoring and review**

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

**Recommendation**

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

*Duncan Rudkin, Chief Executive & Registrar*
*General Pharmaceutical Council*
duncan.rudkin@pharmacyregulation.org
020 3713 7811

08 September 2016
Performance monitoring report: end June 2016
1. Customer services

1.1 Registrations

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>195</td>
<td>2280</td>
</tr>
<tr>
<td>Pharmacy technicians</td>
<td>227</td>
<td>392</td>
</tr>
<tr>
<td>Registered pharmacies</td>
<td>95</td>
<td>104</td>
</tr>
</tbody>
</table>

1.2 Registration totals

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Budgeted</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacists</td>
<td>52,014</td>
<td>52,513</td>
<td>-499</td>
</tr>
<tr>
<td>Pharmacy technicians</td>
<td>23,143</td>
<td>22,863</td>
<td>280</td>
</tr>
<tr>
<td>Registered pharmacies</td>
<td>14,451</td>
<td>14,562</td>
<td>-111</td>
</tr>
</tbody>
</table>

Register totals as at 30 June 2016.

1.3 Median application processing times for pharmacists

<table>
<thead>
<tr>
<th>Median application processing times for pharmacists (working days)</th>
<th>Median application processing times for pharmacy technicians (working days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application receipt to approval</td>
<td>Application receipt to approval</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Application receipt to entry</td>
<td>Application receipt to entry</td>
</tr>
<tr>
<td>18</td>
<td>8</td>
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</tbody>
</table>

Medians calculated for applications during the period 1 April 2016 to 30 June 2016.
1.4 Contact centre

<table>
<thead>
<tr>
<th>Phone</th>
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<th>2016/17</th>
</tr>
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<tbody>
<tr>
<td>Calls made to GPhC</td>
<td>15,449</td>
<td>21,961</td>
</tr>
<tr>
<td></td>
<td>14,096</td>
<td>9,137</td>
</tr>
<tr>
<td></td>
<td>13,642</td>
<td></td>
</tr>
<tr>
<td>Calls answered within 20 seconds (KPI &gt; 80%)</td>
<td>88.7%</td>
<td>75.1%</td>
</tr>
<tr>
<td></td>
<td>86.3%</td>
<td>92.1%</td>
</tr>
<tr>
<td></td>
<td>82.1%</td>
<td></td>
</tr>
<tr>
<td>Calls abandoned (KPI &lt; 5%)</td>
<td>1.2%</td>
<td>3.3%</td>
</tr>
<tr>
<td></td>
<td>2.1%</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>Correspondence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emails actioned within 2 days (KPI &gt; 90%)</td>
<td>100%</td>
<td>97.3%</td>
</tr>
<tr>
<td></td>
<td>97.7%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Call volumes increased significantly in May and June 2016, in line with expectations. Activity at this time was mainly driven by applications to sit the June registration assessment, applications to join the pre-registration scheme for 2016, and submissions for the CPD cycle.

The call abandonment rate target has been achieved every month and over 75% of calls were answered within 20 seconds in both May and June. Email volumes also increased significantly during this period. All emails were actioned within 48 hours of receipt.
### 1.5 Continuing professional development (CPD)

<table>
<thead>
<tr>
<th>CPD volumes</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records requested</td>
<td>2,020</td>
<td>2,298</td>
<td>1,151</td>
<td>1,798</td>
</tr>
<tr>
<td>Submitted by deadline</td>
<td>1,881</td>
<td>2,103</td>
<td>1,135</td>
<td>1,478</td>
</tr>
<tr>
<td>Timely compliance</td>
<td>93.1%</td>
<td>91.5%</td>
<td>98.6%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

#### Submission issues

<table>
<thead>
<tr>
<th>Extensions</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extension requests</td>
<td>60</td>
<td>71</td>
<td>21</td>
<td>59</td>
</tr>
<tr>
<td>Requests granted</td>
<td>56</td>
<td>62</td>
<td>16</td>
<td>59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incomplete</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete records</td>
<td>164</td>
<td>170</td>
<td>46</td>
<td>139</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problems</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem submissions</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Non-compliance action

<table>
<thead>
<tr>
<th>Reminders</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st reminder</td>
<td>83</td>
<td>133</td>
<td>215</td>
<td>1454</td>
</tr>
<tr>
<td>2nd reminder</td>
<td>41</td>
<td>65</td>
<td>173</td>
<td>105</td>
</tr>
<tr>
<td>Notice of intention to remove</td>
<td>24</td>
<td>40</td>
<td>127</td>
<td>103</td>
</tr>
<tr>
<td>Notice of removal</td>
<td>13</td>
<td>23</td>
<td>66</td>
<td>41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Removals</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removals</td>
<td>11</td>
<td>15</td>
<td>55</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remediation</th>
<th>Batch 8 (Apr-15)</th>
<th>Batch 9 (May-15)</th>
<th>Batch 10 (June-15)</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remedial measures</td>
<td>2</td>
<td>11</td>
<td>18</td>
<td>79</td>
</tr>
</tbody>
</table>

*Figures are presented in batches. Batch 8 was generated on 10 April, batch 9 on 1 May and batch 10 on 30 June 2015. The call in March 2016 has been the only call this calendar year.*
GPhC registrants were last called to submit their CPD records in March 2016. This call was generated for 2.5% of the register. Removals from the register (for both non-compliance, and requests for voluntary removal) have significantly decreased since the last report, from 55 to 23. There have also been decreases in the numbers of notices of intention to remove and notices of removals issued during this period.

First reminders for CPD submission were previously issued to registrants after the deadline. However, as of 2016, first reminders were issued before the deadline. The first reminder for the latest call was issued to 1,454 registrants, which is a significant change from the last report as it was sent to 215 registrants. We wanted to see if the reminders before the deadline would affect the compliance rate. We found a timely compliance rate of 82.2% was achieved, compared to 98.6% for the call in June 2015. As a result, we will keep our approach to reminders under review for the next CPD call in 2017.

The number of registrants entered into remedial measures has increased from 18 to 79. This step was taken for those who scored below 50%, or who submitted an insufficient number of records, with three or more records outstanding.
2. Fitness to Practise (FtP)

2.1 Fitness to Practise performance standards

<table>
<thead>
<tr>
<th></th>
<th>Q4 15-16</th>
<th>Q1 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cases triaged during this period</td>
<td>437</td>
<td>433</td>
</tr>
<tr>
<td>Of which cases triaged within 3 days</td>
<td>324</td>
<td>313</td>
</tr>
<tr>
<td>%</td>
<td>74.1%</td>
<td>72.4%</td>
</tr>
</tbody>
</table>

Cases triaged 1 April 2016 to 30 June 2016.

<table>
<thead>
<tr>
<th></th>
<th>Q4 15-16</th>
<th>Q1 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>All stream 1 cases closed pre-IC</td>
<td>155</td>
<td>168</td>
</tr>
<tr>
<td>Of which closed within 3 months</td>
<td>129</td>
<td>128</td>
</tr>
<tr>
<td>%</td>
<td>83.2%</td>
<td>76.2%</td>
</tr>
<tr>
<td>All stream 2 cases closed pre-IC</td>
<td>139</td>
<td>167</td>
</tr>
<tr>
<td>Of which closed within 10 months</td>
<td>117</td>
<td>134</td>
</tr>
<tr>
<td>%</td>
<td>84.2%</td>
<td>80.2%</td>
</tr>
<tr>
<td>All cases closed or referred at IC</td>
<td>44</td>
<td>39</td>
</tr>
<tr>
<td>Of which reach IC within 12 months</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>%</td>
<td>56.8%</td>
<td>56.4%</td>
</tr>
<tr>
<td>All FTP committee cases closed</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Of which closed within 24 months</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>%</td>
<td>65.2%</td>
<td>75.0%</td>
</tr>
</tbody>
</table>
Cases closed 1 April 2016 to 30 June 2016, which may have been opened at any time.

The dataset shows performance across the entire quarter (April 2016 – June 2016) and as compared with the previous quarter (January 2016 - March 2016).

Compared with the previous quarter, performance improved in one standard (cases closed by FtPC within 24 months) which rose from 65% to 75%. Performance remained stable against one standard (cases closed or referred at IC within 12 months), declining in three (cases closed at triage, stream one cases closed pre-IC within 3 months and stream two cases closed pre-IC within 10 months), although all within normal variation.

It is noteworthy that, across quarter 1, the total number of stream one and stream two cases which were closed increased by 14% (stream one closures increasing from 155 to 168 and stream two closures increasing from 139 to 167).
2.2 Cases received and closed

Across the quarter, we closed 97 more cases (522) than the number of concerns we received (425). Compared with the previous quarter, the number of cases closed increased by 23%.

As a result our overall caseload reduced to 646 at the end of June 2016. Across the quarter, the number of concerns being received remained relatively stable. In total 425 concerns were received this reporting period, equating to a monthly average of 142, compared with 437 concerns being received in the previous quarter.
2.3 Caseload age profile

<table>
<thead>
<tr>
<th>Age profile</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June</td>
<td>July</td>
</tr>
<tr>
<td>Under 6 months</td>
<td>No.</td>
<td>379</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>56%</td>
</tr>
<tr>
<td>6-12 months</td>
<td>No.</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>19%</td>
</tr>
<tr>
<td>12-15 months</td>
<td>No.</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>6%</td>
</tr>
<tr>
<td>15 months old and over</td>
<td>No.</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>No.</td>
<td>682</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The age profile of our open caseload remains relatively stable, with continued decreases in the number of cases aged under 6 months and over 12 months which is in line with our plan to proactively manage newer cases at the front end of the process efficiently and effectively, whilst progressing older cases through the various stages of the process to closure.

The number of cases under 6 months reduced by 28% from the previous quarter which reflects the increased number of cases that were closed and the reduction in number of concerns received. The proportion of our caseload over 12 months old has remained stable, although the actual number of cases over 12 months old decreased from 151 at the end of the previous quarter to 141 at the end of this quarter.

Whilst the overall caseload has reduced, the number of cases between 6-12 months has increased. This does not represent a significant increase and largely corresponds with the increased number of concerns received from July to October 2015 and which are
progressing to closure through the fitness to practise process. At the end of June 2016, 141 open cases were 12 months or older, compared with 176 in June 2015

In relation to the 141 open cases over the age of 12 months, 89 (63%) are beyond the investigatory stage on their way to closure. Of those cases:

- 35 have been listed for hearing before the FtPC
- 26 are in the listing process for scheduling to be heard at FtPC before the end of December 2016, with 2 cases to be scheduled before the FtPC before the end of January 2017
- 19 are subject to an interim order
- 10 are listed before the IC in August
- 16 cases are anticipated for closure in July

The remaining 52 cases over the age of 12 months are at the investigation stage. 19 of these are subject to third-party intervention and therefore no further investigation can be undertaken until other agencies have completed their enquiries. Of the remaining 33 cases currently at this stage, 31 are anticipated to have concluded the investigation stage before the end of September 2016. For the remaining 2 cases, we require Court Orders for the disclosure of information, and these are being sought actively.
## 2.4 Cases over 15 months

<table>
<thead>
<tr>
<th>Age profile</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June</td>
<td>November</td>
</tr>
<tr>
<td>15-19 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>%</td>
<td>30.8%</td>
<td>35.7%</td>
</tr>
<tr>
<td>20-24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>37</td>
<td>25</td>
</tr>
<tr>
<td>%</td>
<td>27.8%</td>
<td>22.3%</td>
</tr>
<tr>
<td>25-29 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>%</td>
<td>22.6%</td>
<td>13.4%</td>
</tr>
<tr>
<td>30-34 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>%</td>
<td>6.8%</td>
<td>16.1%</td>
</tr>
<tr>
<td>35-39 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>%</td>
<td>8.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>40-42 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>%</td>
<td>0.0%</td>
<td>6.3%</td>
</tr>
<tr>
<td>43-50 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>2.3%</td>
<td>0.90%</td>
</tr>
<tr>
<td>50 months or more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>1.5%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

The direction of travel in progressing the oldest cases remains positive and in line with our plan to progress these through to closure. Of the 107 cases within this age cohort, 76 (71%) are beyond the investigatory stage and on their way to closure: 4 of these cases are listed to be considered by the IC in August and 16 are anticipated for closure in July. 34 of these cases are listed before the FtPC for
hearing and 22 await listing before the FtPC and are currently in the process of being listed for a FtPC hearing before the end of December 2016. 19 of these cases are subject to an Interim Order

Of the 31 remaining cases within this age profile, 12 are subject to third-party intervention and we are unable to progress the investigation until other agencies have completed their enquiries. 19 cases are within the investigation process and are anticipated to have concluded the investigation stage before the end of September 2016.

Of the 7 cases over 40 months old, 2 are listed for FtPC hearings, 2 are currently in the process of being listed before the FtPC, 1 is planned for closure in July 2016 and 1 is scheduled to be considered by the IC in August 2016. The final case of this age profile is now under investigation, having been subject to third party investigation – we anticipate the investigation to be concluded before the end of September 2016.
2.5 Cases closed by stage

Of note is that the average numbers of cases closed at IC and FiPC has remained stable across this quarter. The number of cases closed at Stream 2 increased month on month throughout this quarter.
2.6 DBS referrals
The Disclosure and Barring Service (DBS) and Disclosure Scotland (DS) Referrals Panel considered 9 matters during this quarter. Two matters were referred to the DBS; no matters were referred to the DS.

2.7 Appeals
At the end of this quarter there were 7 ongoing appeals, 2 of which were received during the period. During this quarter 4 appeals were concluded successfully.
2.8 Interim orders

Since June 2015, the GPhC has made 26 interim order applications, of which 25 were granted and 1 was declined. Interim orders are sought in circumstances where an order is necessary to protect the public, is in the public interest or is necessary to protect the registrant. Across the quarter, our applications for IOs were made in an average of 2.6 weeks, which is consistent with the average set out in the previous period of 2.5 weeks. This is taken as being from the time we receive the relevant information to the date on which the decision to make an interim order is made by FtPC.
3. Inspection

3.1 Inspections undertaken

<table>
<thead>
<tr>
<th></th>
<th>Routine inspections</th>
<th>Follow up inspections</th>
<th>Visits before registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacies</td>
<td>903</td>
<td>66</td>
<td>77</td>
</tr>
</tbody>
</table>

Figures above relate to inspection activity between 1 April 2016 and 30 June 2016.

The number of routine inspections exceeded 900 for the second quarter in succession. The total is less than the previous quarter’s total of 970 (due in part to the long-term absence of one inspector and a significantly higher number of follow-up inspections). The number reflects achievement in April of the second highest number of inspections since the new approach began. We are now seeing a more consistent and sustainable number of routine inspections each month.

3.2 Pharmacy premises not inspected

<table>
<thead>
<tr>
<th>Months since previous inspection</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>November</td>
<td>February</td>
</tr>
<tr>
<td>36-38 months</td>
<td>1,270</td>
<td>32.4%</td>
</tr>
<tr>
<td>39-41 months</td>
<td>1,017</td>
<td>25.8%</td>
</tr>
<tr>
<td>42-47 months</td>
<td>1,334</td>
<td>33.9%</td>
</tr>
<tr>
<td>48 months or more</td>
<td>316</td>
<td>8.0%</td>
</tr>
<tr>
<td>Total</td>
<td>3,937</td>
<td>100%</td>
</tr>
<tr>
<td>Of all registered pharmacies</td>
<td>14,410</td>
<td>27.3%</td>
</tr>
</tbody>
</table>

Figures correct as at 30 June 2016.
3.3 Age profile of pharmacies not inspected for 48 months and over

<table>
<thead>
<tr>
<th>Months since previous inspection</th>
<th>East</th>
<th>%</th>
<th>North</th>
<th>%</th>
<th>South</th>
<th>%</th>
<th>West</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>48 – 50 Months</td>
<td>178</td>
<td>92.2%</td>
<td>108</td>
<td>87.8%</td>
<td>31</td>
<td>96.9%</td>
<td>161</td>
<td>70.3%</td>
<td>478</td>
<td>70%</td>
</tr>
<tr>
<td>51 – 53 Months</td>
<td>12</td>
<td>6.2%</td>
<td>15</td>
<td>12.2%</td>
<td>1</td>
<td>3.1%</td>
<td>60</td>
<td>26.2%</td>
<td>88</td>
<td>26%</td>
</tr>
<tr>
<td>54 – 56 Months</td>
<td>2</td>
<td>1.0%</td>
<td>0.00%</td>
<td></td>
<td>0.00%</td>
<td></td>
<td>8</td>
<td>3.5%</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>+60 Months</td>
<td>1</td>
<td>0.5%</td>
<td>0.00%</td>
<td></td>
<td>0.00%</td>
<td></td>
<td>0.00%</td>
<td></td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>33.4%</td>
<td>123</td>
<td>21.3%</td>
<td>32</td>
<td>5.5%</td>
<td>229</td>
<td>39.7%</td>
<td>577</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figures correct as at 30/06/2016

The number of pharmacies not inspected for more than 36 months has risen to 4,724, an increase of 1.1% from the end of March. The number of pharmacies not inspected for 48 months or more has risen from 516 to 577, although the number not inspected for 54 months or more has fallen from 47 to 11 as part of our on-going plan to reduce those pharmacies that have not been inspected for the longest period.

We continue to target the pharmacies that have not been inspected for 48 months or more, focusing on the oldest in each inspector’s allocated region. We are also continuing to use our floating inspectors to inspect pharmacies in South Wales where we now have a higher number of pharmacies not inspected for 48 months or more although they are currently being deployed to target pharmacies in the Midlands due to the long-term absence of one inspector. We are also using inspectors across other regional boundaries where it is effective and efficient to do so. Our aim is to continue bearing down on the ‘tail-end’ so that we reach and maintain a position whereby all pharmacies are being inspected within 4 ½ years.
### 3.4 Top 5 standards ranked as not met

<table>
<thead>
<tr>
<th>Standard no.</th>
<th>Description</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The risks associated with providing pharmacy services are identified and managed</td>
<td>1</td>
</tr>
<tr>
<td>4.3</td>
<td>Medicines and medical devices are: obtained from a reputable source; safe and fit for purpose; stored securely; safeguarded from unauthorized access; supplied to the patient safely; and disposed of safely and securely</td>
<td>2</td>
</tr>
<tr>
<td>1.2</td>
<td>The safety and quality of pharmacy services are regularly reviewed and monitored</td>
<td>3</td>
</tr>
<tr>
<td>1.6</td>
<td>All necessary records for the safe provision of pharmacy services are kept and maintained</td>
<td>4</td>
</tr>
<tr>
<td>4.2</td>
<td>Pharmacy services are managed safely and effectively</td>
<td>5</td>
</tr>
</tbody>
</table>

### 3.5 Top 5 standards ranked as good

<table>
<thead>
<tr>
<th>Standard no.</th>
<th>Description</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The risks associated with providing pharmacy services are identified and managed</td>
<td>1</td>
</tr>
<tr>
<td>2.2</td>
<td>Staff have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training</td>
<td>2</td>
</tr>
<tr>
<td>2.4</td>
<td>There is a culture of openness, honesty and learning</td>
<td>3</td>
</tr>
<tr>
<td>4.2</td>
<td>Pharmacy services are managed and delivered safely and effectively</td>
<td>4</td>
</tr>
<tr>
<td>1.2</td>
<td>The safety and quality of pharmacy services are regularly reviewed and monitored</td>
<td>5</td>
</tr>
</tbody>
</table>

There has been a slight change in the order of the top 5 standards not met and one change with standard 4.2 – ‘Pharmacy services are managed and delivered safely and effectively’ – replacing standard 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’. The top 5 standards rated ‘good’ have remained the same apart from a minor change in the order.
4. Complaints

4.1 Formal complaints and negative feedback by category

As has been the case previously, the GPhC renewal process accounts for a substantial proportion of complaints received in this reporting period. These relate both to receiving renewal letters, and the process by which payment is made. In addition, two additional areas are referenced in a number of complaints: how concerns are investigated by the GPhC and the thresholds upon which its conclusions are based, and the way in which the GPhC communicates (both verbally and in writing) with registrants and members of the public.
5. Human Resources

5.1 GPhC overview

The data below gives an accurate breakdown of staff movement and absence for each quarter. The figures are pulled off at the end of each quarter so the permanent figure will not always reflect the starters and leavers at a given point as these roll across the quarter.

The sickness days are below and the Directorate figures are based on the actual costs of that member of staff salary for the day they were off sick.

<table>
<thead>
<tr>
<th>GPhC</th>
<th>1 July 2015 – 30 June 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount</td>
<td>215</td>
</tr>
<tr>
<td>Leavers</td>
<td>39</td>
</tr>
<tr>
<td>Dismissal/FTC end</td>
<td>6</td>
</tr>
<tr>
<td>Resignations</td>
<td>33</td>
</tr>
<tr>
<td>Turnover</td>
<td>12.99%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Q3 2015-16</th>
<th>Q4 2015-16</th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations &amp; EDI</td>
<td>63</td>
<td>91</td>
<td>115</td>
<td>146</td>
</tr>
<tr>
<td>Strategy</td>
<td>23</td>
<td>15</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>IFTP</td>
<td>69</td>
<td>137</td>
<td>130</td>
<td>105</td>
</tr>
<tr>
<td>Executive Office</td>
<td>1</td>
<td>11</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Company Total</td>
<td>963.5 Days</td>
<td>30</td>
<td>115</td>
<td>146</td>
</tr>
</tbody>
</table>
### 5.2 Breakdown by Department

#### IFTP

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015-16</th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent staff</strong></td>
<td>79</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td><strong>Fixed term staff</strong></td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Starters</strong></td>
<td>5</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td><strong>Leavers</strong></td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Sickness days</strong></td>
<td>137.5</td>
<td>130.5</td>
<td>105</td>
</tr>
<tr>
<td><strong>Sickness cost</strong></td>
<td>£21,465</td>
<td>£20,064.64</td>
<td>£16,400.91</td>
</tr>
</tbody>
</table>

#### ODEDI

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015-16</th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent staff</strong></td>
<td>7</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td><strong>Fixed term staff</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Starters</strong></td>
<td>0</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Leavers</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sickness days</strong></td>
<td>3</td>
<td>14</td>
<td>29.5</td>
</tr>
<tr>
<td><strong>Sickness cost</strong></td>
<td>£629.70</td>
<td>£1,718.12</td>
<td>£4,181.30</td>
</tr>
</tbody>
</table>
## Operations

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015-16</th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent staff</td>
<td>57</td>
<td>58</td>
<td>61</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Starters</td>
<td>5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Leavers</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Sickness days</td>
<td>88</td>
<td>101</td>
<td>117</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£9,821.32</td>
<td>£14,658.62</td>
<td>£11,293.52</td>
</tr>
</tbody>
</table>

## Executive Office

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015-16</th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent staff</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Starters</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Leavers</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sickness days</td>
<td>11</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£2,343.51</td>
<td>£357.69</td>
<td>£238.90</td>
</tr>
</tbody>
</table>
Strategy

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015-16</th>
<th>Q1 2016-17</th>
<th>Q2 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent staff</td>
<td>27</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>Fixed term staff</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Starters</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Leavers</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Sickness days</td>
<td>15</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Sickness cost</td>
<td>£2244.74</td>
<td>£3,920.63</td>
<td>£3,612.98</td>
</tr>
</tbody>
</table>

It is worth noting that the majority of fixed term employees are fixed to an expiration date of their right to work in the UK.

5.3 Summary

The sickness figures are inflated by eight staff being long term sick (over 20 days) and sharing 304 sickness days between them. Our short term absence KPI is 2.59 days per member of staff per calendar year. The national mean is 2.5 days. However, we are in the process of better using our HR Information system to ensure better recording of absences. Going forward this figure may marginally increase.

The national mean for turnover (percentage of staff who have resigned from total permanent staff over calendar year) is 12.5%. Other regulatory bodies have recently shared reports that show as high as 23%. As can be seen our turnover figure is 12.99%. The HR Department continues to work hard to put into place a number of improvements to increase our retention levels including a corporate induction and training programme, succession planning and better alignment of recruitment to role.
6. Financial performance

6.1 GPhC Balance Sheet as at 30 June 2016

<table>
<thead>
<tr>
<th></th>
<th>Jun 2016</th>
<th>March 2016</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquisitions</td>
<td>7,651</td>
<td>7,625</td>
<td>26</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(2,082)</td>
<td>(1,843)</td>
<td>(239)</td>
</tr>
<tr>
<td></td>
<td>5,569</td>
<td>5,782</td>
<td>(213)</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>413</td>
<td>472</td>
<td>(59)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>1,003</td>
<td>1,194</td>
<td>(191)</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>95</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Escrow</td>
<td>16</td>
<td>30</td>
<td>(14)</td>
</tr>
<tr>
<td>Bank &amp; Cash</td>
<td>24,227</td>
<td>25,621</td>
<td>(1,394)</td>
</tr>
<tr>
<td></td>
<td>25,754</td>
<td>27,362</td>
<td>(1,608)</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>559</td>
<td>1,076</td>
<td>(517)</td>
</tr>
<tr>
<td>Tax due</td>
<td>347</td>
<td>301</td>
<td>46</td>
</tr>
<tr>
<td>Grant Income</td>
<td>676</td>
<td>735</td>
<td>(59)</td>
</tr>
<tr>
<td>Deferred Fee Income</td>
<td>11,761</td>
<td>13,364</td>
<td>(1,603)</td>
</tr>
<tr>
<td>Data Sub Income</td>
<td>10</td>
<td>10</td>
<td>(0)</td>
</tr>
<tr>
<td>Accruals</td>
<td>926</td>
<td>737</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td>14,279</td>
<td>16,223</td>
<td>(1,944)</td>
</tr>
<tr>
<td><strong>Net Current Assets</strong></td>
<td>11,475</td>
<td>11,139</td>
<td>336</td>
</tr>
<tr>
<td><strong>Landlord Incentive</strong></td>
<td>3,499</td>
<td>3,562</td>
<td>(63)</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13,545</td>
<td>13,359</td>
<td>186</td>
</tr>
<tr>
<td><strong>Funds Employed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated B/Fwd</td>
<td>13,359</td>
<td>13,848</td>
<td>(489)</td>
</tr>
<tr>
<td>Surplus/(Deficit) in Year</td>
<td>185</td>
<td>(489)</td>
<td>674</td>
</tr>
<tr>
<td><strong>Total Funds</strong></td>
<td>13,544</td>
<td>13,359</td>
<td>185</td>
</tr>
</tbody>
</table>

Fixed Assets

There was a small movement in leasehold improvement costs; the only other movement is in depreciation for the quarter.

Outstanding debtors include:

- Recovery of legal costs - £52k
- Recovery of Accreditation costs - £29k

Long Term Liabilities

This figure of £3.5m represents the amount the landlord has contributed towards the fit-out costs for our offices offset by the provision for long term rent increases.

The balance sheet shows total fixed assets of £5.6m which is made up of works carried out to our offices, office furniture, computer equipment and development of the CRM project phase 1.

Current assets include accrued bank interest income. The cash balance is due to fees being paid in advance.

Current liabilities of £14.3m include £12.5m deferred income which has been received but not yet credited to the p&l account. This relates to monies received in relation to fee income and working capital grants.
### 6.2 Management Accounts to June 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Qtr 1 Actual</th>
<th>Qtr 1 Budget</th>
<th>Qtr 1 Variance</th>
<th>2017 Budget</th>
<th>2017 Reforecast 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacist Income</strong></td>
<td>3,283</td>
<td>3,212</td>
<td>71</td>
<td>13,588</td>
<td>13,928</td>
</tr>
<tr>
<td><strong>Premises Income</strong></td>
<td>907</td>
<td>925</td>
<td>(18)</td>
<td>3,719</td>
<td>3,631</td>
</tr>
<tr>
<td><strong>Pharmacy Technician Income</strong></td>
<td>697</td>
<td>689</td>
<td>8</td>
<td>2,887</td>
<td>2,887</td>
</tr>
<tr>
<td><strong>Pre-Registration Income</strong></td>
<td>665</td>
<td>657</td>
<td>8</td>
<td>1,225</td>
<td>1,234</td>
</tr>
<tr>
<td><strong>Other Fee Income</strong></td>
<td>6</td>
<td>11</td>
<td>(5)</td>
<td>57</td>
<td>53</td>
</tr>
<tr>
<td><strong>Grants</strong></td>
<td>59</td>
<td>43</td>
<td>16</td>
<td>172</td>
<td>186</td>
</tr>
<tr>
<td><strong>Other Income</strong></td>
<td>76</td>
<td>138</td>
<td>(62)</td>
<td>225</td>
<td>180</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>5,693</td>
<td>5,675</td>
<td>18</td>
<td>21,873</td>
<td>22,099</td>
</tr>
<tr>
<td><strong>Chief Executive</strong></td>
<td>(310)</td>
<td>(354)</td>
<td>44</td>
<td>(1,412)</td>
<td>(1,405)</td>
</tr>
<tr>
<td><strong>Inspections &amp; Fitness to Practise</strong></td>
<td>(1,784)</td>
<td>(1,725)</td>
<td>(59)</td>
<td>(7,199)</td>
<td>(7,401)</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td>(645)</td>
<td>(815)</td>
<td>170</td>
<td>(3,000)</td>
<td>(2,742)</td>
</tr>
<tr>
<td><strong>Organisational Development &amp; EDI</strong></td>
<td>(309)</td>
<td>(294)</td>
<td>(15)</td>
<td>(1,074)</td>
<td>(1,175)</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td>(2,005)</td>
<td>(2,389)</td>
<td>384</td>
<td>(8,447)</td>
<td>(7,722)</td>
</tr>
<tr>
<td><strong>Total Overheads</strong></td>
<td>(5,053)</td>
<td>(5,577)</td>
<td>524</td>
<td>(21,132)</td>
<td>(20,445)</td>
</tr>
<tr>
<td><strong>Outsourced Services</strong></td>
<td>(3)</td>
<td>(5)</td>
<td>2</td>
<td>(19)</td>
<td>(18)</td>
</tr>
<tr>
<td><strong>Rent</strong></td>
<td>(306)</td>
<td>(307)</td>
<td>1</td>
<td>(1,232)</td>
<td>(1,231)</td>
</tr>
<tr>
<td><strong>Rent Contributions</strong></td>
<td>113</td>
<td>113</td>
<td>0</td>
<td>454</td>
<td>454</td>
</tr>
<tr>
<td><strong>Service Charge</strong></td>
<td>(119)</td>
<td>(122)</td>
<td>3</td>
<td>(490)</td>
<td>(487)</td>
</tr>
<tr>
<td><strong>Rates</strong></td>
<td>(132)</td>
<td>(138)</td>
<td>6</td>
<td>(554)</td>
<td>(548)</td>
</tr>
<tr>
<td><strong>Utilities</strong></td>
<td>(31)</td>
<td>(31)</td>
<td>0</td>
<td>(124)</td>
<td>(124)</td>
</tr>
<tr>
<td><strong>Buildings Insurance</strong></td>
<td>(20)</td>
<td>(19)</td>
<td>(1)</td>
<td>(78)</td>
<td>(78)</td>
</tr>
<tr>
<td><strong>Total Occupancy Costs</strong></td>
<td>(498)</td>
<td>(509)</td>
<td>11</td>
<td>(2,043)</td>
<td>(2,032)</td>
</tr>
<tr>
<td><strong>Total Contingency</strong></td>
<td>0</td>
<td>8</td>
<td>(8)</td>
<td>157</td>
<td>(72)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>(5,551)</td>
<td>(6,078)</td>
<td>527</td>
<td>(23,018)</td>
<td>(22,549)</td>
</tr>
<tr>
<td><strong>Net Operating Surplus/ (Deficit)</strong></td>
<td>142</td>
<td>(403)</td>
<td>545</td>
<td>(1,145)</td>
<td>(450)</td>
</tr>
<tr>
<td><strong>before Interest and Tax</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Interest</strong></td>
<td>55</td>
<td>45</td>
<td>10</td>
<td>180</td>
<td>217</td>
</tr>
<tr>
<td><strong>Total Tax</strong></td>
<td>(12)</td>
<td>(10)</td>
<td>(2)</td>
<td>(40)</td>
<td>(63)</td>
</tr>
<tr>
<td><strong>Net Operating Surplus/ (Deficit)</strong></td>
<td>185</td>
<td>(368)</td>
<td>553</td>
<td>(1,005)</td>
<td>(296)</td>
</tr>
</tbody>
</table>

**Net Operating Surplus/ (Deficit) after Interest and Tax**
Commentary

Operating surplus/(deficit) after interest and tax

The result for the year to date is a surplus of £0.2m as opposed to the budgeted deficit of £0.4m. This is due to a combination of cost savings and re-phasing.

The reforecast has recently been completed and the expected result for the year is a £296K deficit, a saving of £709K when compared to the original budget. This amounts to a 2% saving in expenditure overall. The majority of this saving relates to IT costs as expenditure on the transformation project will be lower than budgeted for this financial year, with costs increasing in the next financial year.

Income
Fee income has increased slightly as forecast registrant numbers have been updated in line with actual registrant numbers.

Expenditure

Chief Executive, Council and governance
Council and Committee costs show a saving against budget mainly due to overseas accreditation events not going ahead during the period.

Inspections and Fitness to Practise
Expenditure with panel firms is higher than budgeted for the period due to cases allocated towards the end of the last financial year.

Strategy
The savings to date relate to staff costs and consultancy costs

Organisational Development and EDI
Expenditure is in line with budget.

Operations
Savings are due to staff vacancies and the re-phasing of the IT projects budget due to the transformation agenda.
6.3 Expenditure by Cost Category

Expenditure by Cost Category

- Research Costs: 0.0%
- Marketing Costs: 1.1%
- Other Costs: 2.5%
- Property Cost: 4.5%
- Office Costs: 4.7%
- Event Costs: 7.1%
- Financial Costs: 7.5%
- IT Costs: 9.0%
- Council & Associate Costs: 9.3%
- Employee Costs: 52.4%

6.4 Income by Registrant Type

Total income by registrant type

- Pharmacist Income: 58%
- Premises Income: 16%
- Pharmacy Technician Income: 12%
- Pre-Registration Income: 12%
- Other Fee Income: 1%
- DH Grant Income: 0%
- Other Income: 1%
7. Education

7.1 Accreditation and recognition activity

<table>
<thead>
<tr>
<th>Course</th>
<th>Type</th>
<th>Q4 2015/16</th>
<th>Q1 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPharm degree</td>
<td>Accreditation</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Interim visit</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Independent prescribing</td>
<td>Accreditation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Monitoring visit</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Level 2 medicines counter assistant and dispensing assistant</td>
<td>Accreditation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Reaccreditation</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>OSPAP</td>
<td>Reaccreditation</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

One MPharm provider achieved a successful step 3 and was therefore permitted to register its first cohort of students.

A new 2+2 MPharm degree began the step process and will have two more steps before full accreditation is achieved.

This was the second year of MPharm interim visits. These visits focus on clinical practice activities, patient exposure and inter-professional education. The reports reflect a range of good practice in the undergraduate experience.

Accreditation events for two new independent prescribing programmes took place this quarter, both of which were approved and intend to be delivered from autumn 2016 – this will bring the total number of pharmacist independent prescribing programmes to 42.
Council meeting 08 September 2016  16.09.C.10

Public business

Audit and Risk Committee unconfirmed minutes, 19 July 2016

Recommendation
Council is asked to note the unconfirmed minutes of the Audit and Risk Committee meeting held on 19 July 2016.
Minutes of the Audit and Risk Committee meeting held on Tuesday, 19 July 2016 at 25 Canada Square, London at 1pm

TO BE CONFIRMED 26 OCTOBER 2016

Minutes of the public session

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

Apologies
  Duncan Rudkin (Chief Executive and Registrar)
  Jenny Brown (Grant Thornton)

In attendance
  Pascal Barras (Risk and Assurance Manager)
  Matthew Hayday (Head of Governance)
  Sarah Hillary (Moore Stephens)
  Ruth McGregor (Head of Finance and Procurement)
  Bill Mitchell (Moore Stephens)
  Elaine Mulingani (Associates and Partners Manager) – item 5
  Sue Reed (Council Secretary)

17. ATTENDANCE AND INTRODUCTORY REMARKS
17.1. The chair welcomed members and staff to the meeting.
17.2. Mark Hammond, a new committee member who took up post on 15 April 2016, and Pascal Barras, the new Risk and Assurance Manager, were welcomed to their first meeting of the committee.

18. DECLARATIONS OF INTEREST
18.1. No declarations of interest were made.
19. MINUTES OF LAST MEETING

19.1. The minutes of the public session of the meeting held on 25 May 2016 were agreed as a true record.

20. ACTIONS AND MATTERS ARISING

20.1. Reference minute 5.10 of 25 May 2016 meeting: the chair reported that he would be meeting with the chair of the Remuneration Committee (RemCom) and the chief executive and registrar in September 2016 to discuss the RemCom’s reviews of wider HR strategy with a view to providing the committee with further assurance. He would update the committee at its next meeting on 26 October 2016.

20.2. Reference section 7 of the minutes of 25 May 2016 meeting: Ruth McGregor reported that the Procurement team was working on the process for appointing the external auditors from 2016/17 and that she would update the committee on progress at its next meeting on 26 October 2016. The new national contract arrangements, which had not yet been published, would be taken into consideration following which tenders would be invited from mid-tier suppliers. The appointment would be made in Q4 2016 or early in Q1 2017. Council would be asked to approve the appointment at either its February 2017 or April 2017 meeting.

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

21. INDEPENDENT REVIEW: STATUTORY COMMITTEE FEEDBACK

21.1. Elaine Mulingani (EM) presented 16.07.ARC.01 – Dr Anna van der Gaag’s report entitled An independent review of the statutory committee internal feedback mechanisms of the General Pharmaceutical Council. EM also gave a presentation entitled Statutory committees: review of internal feedback mechanisms which outlined management’s response to the report’s recommendations and agreed actions.

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

- the sample had been around 10 randomised participants and had not included the Appointments Committee (AC) chair
- a review of the whistleblowing policy and procedure to be added to the committee’s work plan

ACTION: MH

- panel members would be invited to provide feedback after every hearing they attended
it was important to recognise that the cultures of the Investigations Committee and the Fitness to Practise Committee might, given the nature of their work, differ from each other

the role specification for the new AC chair would reflect the report’s recommendations

the committee would welcome a Council workshop to review the whistleblowing arrangements

Dr van der Gaag’s thanks and the positive feedback in her report would be communicated to staff, participants and the Professional Standards Authority

Council members would be most welcome to observe a tribunal, and should advise EM if they wished to do so

a progress report would be presented to the committee at its May 2017 meeting

21.3. The chair thanked EM and her team for all their good work on the project.

21.4. The committee noted:

(i) the report entitled An independent review of the statutory committee internal feedback mechanisms of the General Pharmaceutical Council

(ii) the presentation outlining management’s response to the report and agreed actions

(iii) that a progress report would be presented to the committee at its May 2017 meeting

22. ASSURANCE REVIEWS PROGRESS REPORT

22.1. Matthew Hayday (MH) presented 16.07.ARC.02 which summarised progress on actions arising from assurance reviews undertaken since May 2014.

22.2. MH also gave the following update on the two outstanding points in Appendix 1 relating to information governance and IT projects:

- secure virtual private network and mobile device management had been rolled out

- third party supplier assurance:
  - regular meetings were held with the A365 security manager, and work was underway to develop an Information Security Management System. The IT governance auditor had met with the A365 security manager as part of the January 2016 audit
work was ongoing to source other suppliers in line with the Data Protection Act and information security standard contract terms and conditions, and a bank of requirements and questions for invitations to tender and a procurement checklist for the new procurement procedures manual were being developed
work was underway with the procurement team to review security as contracts came up for renewal

• penetration testing:
  • checks had included the website (and MyGPhC sites). Social media accounts had not been included but had strong passwords which were changed quarterly or when the site reported a security concern
  • penetration tests were run based on advice on current threats and changes in the security environment from the supplier, so were reviewed and updated each time they were commissioned. They did not currently include social engineering but could do so if required. The options and costs would be investigated

22.3. In response to a member’s concern that passwords for public-facing social media accounts were shared across devices, it was agreed that a summary of the controls in place would be presented to the committee at its next meeting on 26 October 2016.

ACTION: MH

22.4. The committee noted progress made on the actions arising from the assurance reviews.

23. INTERNAL AUDIT REPORTS

Internal Audit Plan 2016/17 update

23.1. Bill Mitchell (BM) presented 16.07.ARC.03 which summarised progress and proposed changes to the Internal Audit Plan 2016/17. The committee’s attention was drawn to paragraph 3.1 which set out the three proposed changes to the Internal Audit Plan.

23.2. The committee:
  (i) approved the proposed changes to the Internal Audit Plan 2016/17 as set out in paragraph 3.1, and reaffirmed the importance of monitoring the effectiveness of external legal provision and costs
  (ii) noted progress to date
Internal audit advisory report: Data quality for better regulation

23.3. The committee received and noted the final version of the above referenced internal audit advisory report and noted the agreed management actions and timescales.

24. ANY OTHER BUSINESS

24.1. There being no further business, the public session closed at 2.05pm.

DATE OF NEXT MEETING

Wednesday, 26 October 2016 at 2pm
Public business

Council member appointments 2017

Purpose
To confirm how Council vacancies will be filled in the recruitment for 2017.

Recommendations
Council is asked to agree that the recruitment for Council vacancies commencing in April 2017 will be filled using a combination of open competition and a reappointments process.

1. Introduction
1.1 In April 2014 Council agreed that, in general, future Council appointments would be made using a mixture of open recruitment and reappointments. However, this would be reviewed on a case by case basis, following the relevant procedure. Reappointments were made for the first time in April 2016.

1.2 This paper is the first step in the process for appointments in 2017.

2. Process for Council member appointments in 2017
2.1 In line with the procedure Council is asked to determine whether the recruitment in 2017 will be through open competition, reappointment or a combination of the two.

2.2 Council should note that, of the five members whose appointments end in March 2017, two are not eligible for reappointment and therefore the process will include some open competition.

2.3 Council should also consider the following when deciding on whether to use reappointments:
   - assess and consider the current and future needs of Council for particular skills and expertise
• consider the balance between continuity and refreshment of Council’s membership. The aim should be to produce a degree of change which minimises the risks of stagnation on the one hand, and instability and delays on the other
• consider the diversity of backgrounds within Council’s membership
• take account of any relevant external factors, for example, anticipated changes to the constitution of the Council

2.4 Taking the above factors into account there appears to be no reason why Council cannot proceed with its general principle of using a mixture of open competition and reappointments:
• in recent workshop discussion Council did not identify any specific skills or expertise that it required in the immediate future
• given that there will be at least two vacancies appointed to by open competition this will address the issue of balancing continuity and refreshment of the membership
• there are no planned changes to the Council’s constitution

2.5 Should Council approve the use of reappointments for the relevant vacancies the process would run concurrently with the open recruitment process, which starts later in September 2016 and concludes in March 2017.

3. **Equality and diversity implications**

3.1 A full equality analysis has been completed in advance of the planned Council member recruitment. The Governance team is conscious of the importance of seeking to attract a broad, diverse range of suitably qualified candidates in the Council member recruitment exercises, and the need to conduct the recruitment and selection processes in line with good practice in relation to equality and diversity.

3.2 Changes were made to recruitment process to increase accessibility including further clarifying the essential criteria and simplifying the application form.

4. **Communications**

4.1 Subject to Council’s decision, the Head of Governance will contact those members that are eligible for reappointment and begin the next steps of the procedure no earlier than six months from when their appointments are due to end.

5. **Resource implications**

5.1 The Council appointment process is covered by the relevant operational budgets.
6. **Risk implications**

6.1 Failure to ensure that our appointment process meets the four principles of merit, fairness, transparency and openness, and inspiring confidence in regulation means that the Professional Standards Authority may not have confidence in our process. This would result in the Privy Council not making the appointments we recommend.

7. **Monitoring and review**

7.1 Council will be asked to confirm the process for making appointments prior to the start of any recruitment campaign.

**Recommendations**

Council is asked to agree that the recruitment for Council vacancies commencing in April 2017 will be filled using a combination of open competition and a reappointments process.

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30 August 2016