

# Council meeting

Zoom

Thursday, 10 November 2022

## Public meeting at 13.00

### Public business

#### Standing Items

- |    |                                                                                           |                                   |
|----|-------------------------------------------------------------------------------------------|-----------------------------------|
| 1. | Attendance and introductory remarks                                                       | Gisela Abbam                      |
| 2. | Declarations of interest – public items                                                   | Gisela Abbam                      |
| 3. | Minutes of the 8 September meeting<br><i>Minutes of the public session – for approval</i> | <b>22.11.C.01</b><br>Gisela Abbam |
| 4. | Actions and matters arising                                                               | <b>22.11.C.02</b><br>Gisela Abbam |
| 5. | Workshop summary – 8 September meeting<br><i>For noting</i>                               | <b>22.11.C.03</b><br>Gisela Abbam |

#### Regulatory functions

- |     |                                                                                   |                                       |
|-----|-----------------------------------------------------------------------------------|---------------------------------------|
| 6.  | EDI strategy: six-month update (Year 1)<br><i>For discussion</i>                  | <b>22.11.C.04</b><br>Laura McClintock |
| 7.  | Equality guidance for pharmacies<br><i>For approval</i>                           | <b>22.11.C.05</b><br>Annette Ashley   |
| 8.  | Fitness to Practise hearings format guidance<br><i>For approval</i>               | <b>22.11.C.06</b><br>Paul Cummins     |
| 9.  | Outcome of the PSA performance review 2021/22<br><i>For discussion and noting</i> | <b>22.11.C.07</b><br>Duncan Rudkin    |
| 10. | Post registration assurance of practice update<br><i>For noting</i>               | <b>22.11.C.08</b><br>Mark Voce        |

## Governance, finance and organisational management

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|------------|------------------------------------------------------------------------------------------------------------------------|-------------------|
| <b>11.</b> | <b>Performance reporting for Q2 2022/23</b>                                                                            | <b>22.11.C.09</b> |
|            | <i>For discussion</i>                                                                                                  |                   |
| <b>12.</b> | <b>Communications and engagement update</b>                                                                            | <b>22.11.C.10</b> |
|            | <i>For discussion</i>                                                                                                  | Rachael Gould     |
| <b>13.</b> | <b>Re-appointment of Council members</b>                                                                               | <b>22.11.C.11</b> |
|            | <i>For approval</i>                                                                                                    | Janet Collins     |
| <b>14.</b> | <b>Committee minutes</b>                                                                                               | <b>22.11.C.12</b> |
|            | <ul style="list-style-type: none"><li>Draft minutes of the public items from the ARC meeting on 22 September</li></ul> |                   |
|            | <i>For noting</i>                                                                                                      |                   |
| <b>15.</b> | <b>Any other business</b>                                                                                              | Gisela Abbam      |

## Confidential business<sup>1</sup>

### Standing items

- |            |                                                           |                   |
|------------|-----------------------------------------------------------|-------------------|
| <b>16.</b> | <b>Minutes of the 8 September meeting</b>                 | <b>22.11.C.13</b> |
|            | <i>Minutes of the confidential session – for approval</i> | Gisela Abbam      |

### Regulatory functions

- |            |                                         |                   |
|------------|-----------------------------------------|-------------------|
| <b>17.</b> | <b>Extending the temporary register</b> | <b>22.11.C.14</b> |
|            | <i>For discussion</i>                   | Mark Voce         |

## Governance, finance and organisational management

- |            |                                    |                          |
|------------|------------------------------------|--------------------------|
| <b>18.</b> | <b>Review of investment policy</b> | <b>22.11.C.15</b>        |
|            | <i>For approval</i>                | <b>Jonathan Bennetts</b> |

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<sup>1</sup> The Council's Governance Policy (GPhC0040, agreed December 2019) states that the Council may take business as confidential when the item:

- a. may be prejudicial to the effective conduct of the GPhC's functions if discussed in public; or
- b. contains information which has been provided to the Council in confidence; or
- c. contains information whose disclosure is legally prohibited, or is covered by legal privilege; or
- d. is part of a continuing discussion or investigation and the outcome could be jeopardised by public discussion; or
- e. refers to an individual or organisation that could be prejudiced by public discussion; or
- f. relates to negotiating positions or submissions to other bodies; or
- g. could be prejudicial to the commercial interest of an organisation or individual if discussed in public session; or
- h. could be prejudicial to the free and frank provision of advice or the exchange of views for the purpose of deliberation if discussed in public; or
- i. needs to be discussed in confidence due to the external context, for example, during periods of heightened sensitivity such as during an election period.

- |                                                                                                                                                                                                                                                                                                                                                                                 |                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| <b>19. Approval of lease</b><br><i>For approval</i>                                                                                                                                                                                                                                                                                                                             | <b>22.11.C.16</b><br>Jonathan Bennetts |
| <b>20. Appointment of external auditors</b><br><i>For approval</i>                                                                                                                                                                                                                                                                                                              | <b>22.11.C.17</b><br>Jonathan Bennetts |
| <b>21. Reward matters</b><br><i>For approval</i>                                                                                                                                                                                                                                                                                                                                | <b>22.11.C.18</b><br>Gary Sharp        |
| <b>22. Committee minutes:</b> <ul style="list-style-type: none"><li>• Draft minutes of the confidential items from the ARC meeting on 22 September</li><li>• Draft minutes of the FPC meeting held on 26 September</li><li>• Draft minutes of the QPAC meeting held on 14 September</li><li>• Draft minutes of the WfC meeting held on 30 September</li></ul> <i>For noting</i> | <b>22.11.C.19-22</b><br>Gisela         |
| <b>23. Any other business</b>                                                                                                                                                                                                                                                                                                                                                   | Gisela Abbam                           |

#### **Date of next meeting**

Thursday, 8 December 2022 – in person

# Minutes of the Council meeting held on 8 September 2022

*To be confirmed 10 November 2022*

## Minutes of the public items

### Present:

Gisela Abbam (Chair)	Penny Mee-Bishop
Yousaf Ahmad	Arun Midha
Neil Buckley	Rose Marie Parr
Ann Jacklin	Aamer Safdar
Jo Kember	Jayne Salt
Rima Makarem	Selina Ullah

### Apologies:

Mark Hammond  
Elizabeth Mailey

### In attendance:

Duncan Rudkin	Chief Executive and Registrar
Carole Auchterlonie	Director of Fitness to Practise
Jonathan Bennetts	Director of Adjudication and Financial Services
Claire-Bryce Smith	Director for Insight, Intelligence and Inspection
Laura McClintock	Chief of Staff and Associate Director of Corporate Affairs
Gary Sharp	Associate Director of HR
Mark Voce	Director of Education and Standards
Annette Ashley	Head of Policy and Standards

Damian Day	Head of Education
Rachael Gould	Head of Communications
Sarah Stein	Head of Registration and Customer Services
Janet Collins	Senior Governance Manager
Elisabeth Davies	Chair of the Assurance and Appointments Committee

## Standing items

### 1. Attendance and introductory remarks

- 1.1 The Chair welcomed those present to the meeting. Apologies had been received from Mark Hammond and Elizabeth Mailey.

### 2. Declarations of interest

- 2.1 The Chair reminded members of the Council to make any appropriate declarations of interest at the start of the relevant item.

### 3. Minutes of the last meeting (22.09.C.01)

- 3.1 The minutes of the public session held on 14 July 2022 were approved as a true and accurate record of the meeting.

### 4. Actions and matters arising (22.09.C.02)

- 4.1 The policy on remote hearings had been rescheduled to the November meeting due to pressure on the agenda.

### 5. Workshop summary (22.09.C.03)

- 5.1 The summary of the workshop held on 14 July 2022 was noted.

## Regulatory functions

### 6. Reporting on the June 2022 Registration Assessment sitting (22.09.C.04)

- 6.1 Aamer Safdar declared an interest in this item due to his role as Health Education England Associate Head of Pharmacy for London and the South East.
- 6.2 Mark Voce presented a report on candidate performance in the June 2022 sitting of the Registration Assessment and the ongoing operational preparation for the November sitting.
- 6.3 The June sitting had been undertaken by 2697 candidates with a pass rate of 80%, which was comparable to pass rates for previous summer sittings. There was no statistically significant variation in the pass rate at centres which had experienced serious delays.
- 6.4 Candidate data showed that those who had completed their Foundation Training in hospital, hospital/general practice or multi-sector settings performed better than those who had been in community or community/general practice. There remained a differential pass rate associated with ethnicity, as detailed in the paper. EDI continued to be a focus of accreditation and the new standards for initial education and training included a requirement for an annual review of student

performance based on the protected characteristics with documented action to address any differences identified.

- 6.5 Of the 30 courses run by pharmacy schools, 19 had first-sitting pass rates of between 80-100%, six were between 70-79%, four between 60-69% and one (the University of Central Lancashire) was below 60%.
- 6.6 The reliability indices for both papers were good, at 0.875 for paper 1 and 0.883 for paper 2. The balance of questions was shown to be consistent with the required framework.
- 6.7 Following the problems experienced by some candidates at the June sitting, candidates who experienced delays of 30 minutes or more had received refunds, confirmation that the sitting would not count towards their three attempts if they did not pass and confirmation that they were eligible for provisional registration. 126 appeals had been decided to date, of which 103 had been upheld, primarily due to grounds relating to delays or technical issues. A further 53 candidates were automatically regarded as having a successful appeal due to delays of 30 minutes or more.
- 6.8 In relation to the November sitting, detailed information had been requested from BTL on the changes to delivery and assurance mechanisms, including a two-day face-to-face meeting. The details would be reviewed by the Quality and Performance Assurance Committee (QPAC) but MV gave a high-level update.
- *Test centres, booking and allocation of places:* Candidates would be allocated test centres based on their provided address to reduce worry about getting a place;
  - *GPhC representatives:* GPhC representatives would be present in every test centre (with PSNI representatives in Northern Ireland) to ensure direct communication, verify that centres were correctly equipped the day before the assessment and to provide reports following the sitting;
  - *Types and location of centres:* only permanent test centres would be used, mitigating the risk of late delivery of equipment which had been the primary cause of delays in June. All test centres were being audited for suitability before final selection;
  - *IT issues:* Additional assurance and evidence of testing and checks was being sought to address the IT issues experienced by some candidates;
  - *Invigilators:* Enhanced training would be given to invigilators;
  - *Contingencies:* Staff were continuing to work through the practicalities of contingency planning.
- 6.9 The approach was focused on securing firm evidence of the assurance mechanisms put in place by BTL.
- 6.10 There would be thorough communication with candidates throughout the process but also communication with the wider profession to provide reassurance.
- 6.11 It was noted in the discussion that the diversity statistics for the June sitting raised some interesting points which needed to be examined further. Council would have a detailed discussion on this at a future meeting.

**Action: Council to discuss diversity and pharmacy school statistics from the June sitting of the registration assessment**

- 6.12 **Following the discussion, the Council noted:**

**i) the candidate performance data provided at Annex 1;**

- ii) the Board of Assessors report to Council at Annex 2 and the assurance it provided about the June 2022 sitting;
- iii) the ongoing operation preparation for the November sitting and identified issues to inform the discussion of the QPAC on 14 September.

## **7. Guidance on standards for the education and training of pharmacist independent prescribers (22.09.C.05)**

- 7.1 MV also presented this paper which set out draft guidance in support of the changes to the independent prescribing standards for pharmacists.
- 7.2 Following consultation, the Council had previously agreed to the removal of the requirement for pharmacists wanting to train as independent prescribers to have two years of clinical practice and relevant experience in a specific clinical or therapeutic area. This had been replaced by a requirement to have relevant experience in a UK pharmacy setting and the ability to recognise, understand and articulate the skills and attributes required of a prescriber. It was agreed that guidance would be produced to support consistency in the way that education providers applied the new standards and to help pharmacists understand the experience that they would need before enrolling on an independent prescribing course.
- 7.3 Subject to Council's approval, the guidance would be referred to the Initial Education and Training Advisory Group for any final comments. Rose Marie Parr, co-Chair of the Group, welcomed the draft guidance and confirmed that she would be happy to present it to them.
- 7.4 Council was pleased to see that the draft guidance made reference to the Royal Pharmaceutical Society competence framework for prescribing.
- 7.5 Although the guidance was designed to be enabling, accreditation of prescribing courses would check that it was being followed.
- 7.8 **The Council approved the draft 'Education and training of pharmacist prescribers: guidance to support the introduction of the revised entry requirements', subject to any final comments from the Initial Education and Training Advisory Group.**

## **8. Key issues in the external context: online pharmacy services (22.09.C.06)**

- 8.1 Annette Ashley presented this item, which was an update following a discussion in December 2021.
- 8.2 Jo Kember declared an interest as the Controlled Drugs lead for Wales.
- 8.3 Innovation in the provision of pharmacy services could provide benefits to patients and the workforce but needed to be safe. Providing pharmacy services at a distance, particularly online, carried specific risks which needed to be managed, including:
  - fast changing models of delivery which were immature;
  - operating within a national policy and legislative framework which pre-date these models;
  - in some cases an element of unconscious incompetence and under-developed clinical governance structures; and
  - growing public demand for online services but little public awareness of the differences and risks in using online services.

- 8.4 One of the most pressing current concerns was the prescribing of medicines based solely on the completion of a patient questionnaire. This was a particular concern where it was the sole mode of consultation for high-volume supplies of high-risk medicines. Concerns included the lack of opportunity for a dialogue, difficulty in corroborating the answers without access to medical records, the ease with which a purchaser could identify questions which could cause concerns and the inability to determine whether a patient had read and understood the information provided with the medicine.
- 8.5 The paper set out the actions which the GPhC had taken in this area including the provision of updated guidance, promotion of the Royal Pharmaceutical Society's competency framework for prescribers and advice to patients on buying medicines safely online.
- 8.6 Inspections of 187 online pharmacies using questionnaire models had resulted in only 66% meeting all the required standards (compared to 88% of community pharmacies). Enforcement action had been taken against over 40 online pharmacies.
- 8.7 Concerns about online pharmacy services had an impact on the Fitness to Practise caseload, with over 30% of open cases relating to online services despite only 4.6% of registered pharmacies being known to provide them (639 pharmacies from a total of 13849).
- 8.8 There were complex and challenging issues around whether the dispensing of private prescriptions should be subject to any restrictions, particularly in relation to children with gender incongruence or dysphoria. The GPhC was proactively engaging with stakeholders including Dr Hilary Cass, the leader of the NHS England review tasked with making recommendations on the service provided to children and young people exploring their gender identity. There would be further discussions with Council.
- 8.9 This was also an issue in relation to children's mental health, where pressure on child and adolescent mental health services (CAMHS) were leading families to reach out to private prescribers.
- 8.10 GPhC Inspectors were liaising with local intelligence networks across the three countries and sharing their findings with the departments of Health, including questions of whether certain medicines and controlled drugs should be available online.
- 8.11 The advisory group looking at post-registration education and training was also looking at the issues and working with a range of pharmacy bodies on how to best assure online prescribing among other areas of risk.

## **9. Key issues in the external context: temporary pharmacy closures (22.09.C.07)**

- 9.1 Duncan Rudkin presented the paper, which had been prepared by Laura McClintock.
- 9.2 Yousaf Ahmad declared an interest as an ICS Chief Pharmacist and Director of Medicines.
- 9.3 There had been various reports in recent months of temporary pharmacy closures. Access to pharmacy services was of great importance to patients, families and carers and closures could therefore be distressing and may raise issues of patient safety. Closures were one aspect of a complex set of issues affecting the pharmacy sector.
- 9.4 The causes of closures were complex and multi-factorial, including financial, commercial, workforce and contractual factors. In relation to the GPhC, work on this issue also crossed several functions. This was an area where regulation did not control the key levers and so the regulator's locus was limited. It was important that the GPhC was positive where it could be but open about



its limitations. Where regulatory issues did arise, it was important that the organisation took appropriate action.

- 9.5 The GPhC could be involved in the behavioural standards expected of individuals and businesses in relation to closures, in liaising with other authorities, setting the tone for debates and taking a patient safety approach to service continuity.
- 9.6 Inspectors were exploring this issue from a risk management perspective, looking not just at the pharmacy but also the impact on the local community.
- 9.7 Given the pressures on health services, all healthcare regulators were looking at workforce issues and providing information to employers and policy makers.
- 9.8 The issue would return to Council as part of a discussion on the wellbeing of the pharmacy workforce.

## **Governance, finance and organisational management**

### **10. Assurance and Appointments Committee (AAC) report to Council (22.09.C.08)**

- 10.1 Elisabeth Davies (ED), Chair of the AAC, joined the meeting to present this item which covered work carried out by the AAC over the previous two years.
- 10.2 Since the report had been written, the interviews for lay members mentioned had been held and three new lay members had been recruited.
- 10.3 In discussing the report, members asked questions about some Fitness to Practise panel members feeling that they did not get enough sitting days and whether members could sit on the Investigating Committee and a Fitness to Practise committee as a possible solution. ED explained that this was not possible as the two required different skills sets and there would be a conflict of interest if a member of an FtP committee had already considered a case at the Investigating Committee, hence it was not permitted in the legislation.
- 10.4 **The Council noted the annual report of the Assurance and Appointments Committee and approved its updated Terms of Reference.**

### **11. Any other business**

- 11.1 Gisela Abbam and Duncan Rudkin had attended the launch of the Professional Standards Authority's report *Safe Care for all – solutions from professional regulation and beyond*. The report examined key issues from the perspective of professional regulation across four themes: tackling inequalities; regulating for new risks; facing up to the workforce crisis; and accountability, fear and public safety. Council would discuss the report at a future meeting.
- 11.2 There being no other public business, the meeting closed at 2.45 p.m.

## Council action log – November 2022

	Open and on track
	Overdue
	Rescheduled
	Complete

No.	Status	Minutes	Action	Lead	Update	Due date
2	Rescheduled	April para 7.4	Appraisal policy for independent members of non-statutory committees to be drafted	JC	Rescheduled on agreement with the Chair to November, given full agenda for September.  Circulated for agreement by email as November agenda also full	November
4	Open	September Para 6.11	Council to discuss diversity and pharmacy school statistics from the June sitting of the registration assessment	MV		April 2023
5	Open	September Para 8.8	Council to have a further discussion about pharmaceutical care for children and young people	DR	On the agenda for this meeting	November 2022
6	Open	September Para 9.8	Council to discuss issues around pharmacy workforce wellbeing	DR		December 2022

No.	Status	Minutes	Action	Lead	Update	Due date
7	Open	September 11.1	Council to discuss the PSA's report <i>Safer Care for all</i>	DR	On the agenda for December	December 2022

# Council workshop summary

## Meeting paper for Council on 10 November 2022

Public

### Purpose

To provide an outline of the discussions at the Council workshop on 8 September 2022.

### Recommendations

The Council is asked to note the discussions from the September 2022 workshop.

#### 1. Introduction

- 1.1 The Council often holds a workshop session alongside its regular Council meetings. The workshops give Council members the opportunity to:
  - interact with and gain insights from staff responsible for delivering regulatory functions and projects;
  - receive information on projects during the development stages; provide guidance on the direction of travel for workstreams via feedback from group work or plenary discussion; and
  - receive training and other updates.
- 1.2 The workshops are informal discussion sessions to assist the development of the Council's views. A summary of the workshop discussions is presented at the subsequent Council meeting, making the development of work streams more visible to stakeholders. Some confidential items may not be reported on in full

#### 2. Summary of September 2022 workshop

##### **The new Government**

- 2.1 Duncan Rudkin highlighted three key points in relation to the new UK Government.
- 2.2 Firstly, it would be important to monitor how the new UK Government approached devolution and its relationships with the Scottish and Welsh Governments. Secondly – and whatever the shape of the emerging UK Government and policy, it was inevitable that workforce issues would continue to be central. Professional regulation, in as much as it impacted on workforce, would therefore continue to be relevant. Finally, there was expected to be continued focus on the growth and proliferation of new service models, roles and innovation. The GPhC would continue to engage actively in discussions about the assurance and regulation of new models and services.

- 2.3 The GPhC would be writing to the new Prime Minister and Secretary of State for Health and Social Care to provide briefings on pharmacy regulation and request a meeting.

#### **The quality assurance (QA) of pharmacy education**

- 2.4 Damian Day and Mark Voce presented a session on the quality assurance of pharmacy education including the current QA process; the initial education and training (IET) of pharmacists (with pharmacy technicians to be covered in another session); issues; work in progress; and the implementation of the new IET standards for pharmacists.
- 2.5 From 2024, the GPhC would accredit foundation training delivered by statutory education bodies and partners as well as MPharm degree courses – meaning that the full five years of IET would be GPhC- accredited.
- 2.6 There were currently 30 schools of pharmacy across Great Britain with c.12000 undergraduate students. All schools offered the four-year MPharm degree and 15 also offered a course with an added preparatory year. There were also 46 independent prescribing courses.
- 2.7 More applications for accreditation were refused than were accepted. Where accreditation was granted it was initially for a set period – usually six years with an interim visit after three years. Re-accreditation was also usually for six years with an interim visit after three but this had been shortened in cases where there were concerns.
- 2.8 The GPhC could impose probation with an action plan if necessary and the Council had the power under the Pharmacy Order to remove accreditation, subject to appeal.
- 2.9 Differential attainment in the registration assessment by graduates from the different schools was being monitored, as was attainment by students with differing protected characteristics. The new IET standards included specific requirements such as an annual review of student performance by protected characteristic with documented actions to address differences.

#### **The Fitness to Practise (FtP) process**

- 2.8 Carole Auchterlonie was joined by Alicia Marsh, Mohammed Chowdhury and Hannah Fellows to present this session.
- 2.9 The session covered the handling of concerns from receipt, into the FtP process and on to a full FtP hearing, covering all the stages and possible outcomes inbetween.

### **3. Recommendations**

The Council is asked to note the discussions from the September 2022 workshop.

Janet Collins, Senior Governance Manager  
General Pharmaceutical Council

20/09/2022

# Delivering equality, improving diversity and fostering inclusion: six-month strategy update (Year 1)

## Meeting paper for Council on 10 November 2022

Public session

### Purpose

To update Council on the delivery of the first six months of our new EDI strategy.

### Recommendations

To note and discuss the six-month strategy update for Year 1 (2022/23), attached at Appendix 1.

#### 1. Introduction

- 1.1 Our new EDI Strategy was published at the end of last year. We also took forward several strands of new EDI work at the same time as developing, consulting on and publishing the new strategy. These were summarised in the GPhC annual report 21/22, as agreed by the Council.
- 1.2 Following publication of the strategy, we developed new governance arrangements and set up a new EDI Strategic Leadership Group, to help oversee strategy implementation and create an operational action plan for Year 1 (22/23), aligned to our strategic themes and objectives. This group is made up of key internal stakeholders as well as senior managers/leaders, representing different parts of the organisation.
- 1.3 At the beginning of 2022, we shared and discussed our new operational action plan with the Council, to ensure broad support for the direction of travel. Given the level of operational detail in the action plan, Council agreed to receive six-monthly strategy updates going forward.
- 1.4 This paper represents the first of those updates to Council. **Appendix 1** summarises the key activity and progress that we have made in the first six months of Year 1 (22/23).

#### 2. Progress summary

- 2.1 Overall, the RAG status for progress against each theme to date shows that we are currently on track to deliver against agreed actions for Year 1, with most actions either in progress or completed. Other actions are scheduled for Quarters 3 and 4, and some actions are scheduled to commence in Year 2 and beyond.
- 2.2 We have seen high levels of positive engagement with the strategy and the action plan from across the organisation, with increased levels of awareness amongst staff in terms of our commitment and actions.

- 2.3 An overview of progress is provided in the attached report (**Appendix 1**), aligned to our strategic themes and objectives.

### **3. Benchmarking and evaluation**

- 3.1 It's important to note that we are in the first year of a comprehensive programme of work, so the main focus of our effort has been on setting foundations and improving organisational awareness, developing new EDI policies and procedures, as well as starting to develop new and different approaches to EDI at the GPhC, including being more proactive about tackling discrimination and inequality and speaking out on EDI issues affecting the public and the professions.
- 3.2 At this stage, we are also working closely with our Data & Insight team to develop an evaluation framework, to help us understand the impact of our strategy (with similar work happening for our managing concerns and communications and engagement strategies). This will include collecting and analysing data from different sources to inform the evaluation, with some support expected from external evaluators. Although this work is still in development, we expect the evaluation is likely to focus on the following areas:
- How has the strategy made a difference for public and patients?
  - How has the strategy made a difference for registrants and students?
  - How has the strategy affected our reputation as a regulator?
  - How has the strategy made the GPhC a more inclusive place to work?
  - Is the strategy delivery working?

### **4. Communications**

- 4.1 Regular updates on strategy progress are shared internally, including quarterly updates to the Senior Leadership Group, online communications to all staff via Infopoint, and regular meetings and discussions with the new staff Inclusion Network.
- 4.2 We have also improved the EDI page on the GPhC external website, with updates about our EDI strategy and associated work, including topical articles, case studies and other resources in one place. These are set out in more detail in the update report in Appendix A.

### **5. Resource implications**

- 5.1 All Year 1 activity has been undertaken within existing resources. In terms of forward planning, action owners have been asked to consider any activity which may require additional resources for Year 2 and beyond. This forms an important aspect of the regular EDI Strategic Leadership Group discussions, and colleagues from our Finance team are part of that group.

### **6. Risk implications**

- 6.1 The agreed approach for reporting to Council every six months supports the delivery of the EDI strategy by ensuring that Council is sighted on progress and can help provide strategic guidance and support.
- 6.2 We will also continue to report to Council on individual EDI items as and when more in-depth discussion or approval is needed. For example, at this meeting, we are asking Council to approve the new equality guidance for registered pharmacies, which is an important objective under Theme 3 of the new strategy.

- 6.3 Our new governance arrangements (including the EDI Strategic Leadership Group) and the programme of evaluation will support us to measure the impact and respond accordingly to any issues that arise during the implementation period.

## **7. Monitoring and review**

- 7.1 As mentioned above, our progress is monitored and reviewed on a quarterly basis by the Senior Leadership Group, to allow timely reporting and to ensure that appropriate action can be taken, or direction provided should this be necessary.
- 7.2 We will continue to report to Council every six months. A further update report will be provided to Council at the end of this financial year. This will include progress in Q3 and Q4 of Year 1.

## **Recommendations**

To note and discuss the six-month strategy update for Year 1 (2022/23), attached at Appendix 1.

Laura McClintock, Chief of Staff/Associate Director, Corporate Affairs  
Arvind Sandhu, EDI Policy Manager  
Liliana Corrieri, EDI Business Partner

24/10/2022



# Delivering equality, fostering inclusion and improving diversity: our strategy for change

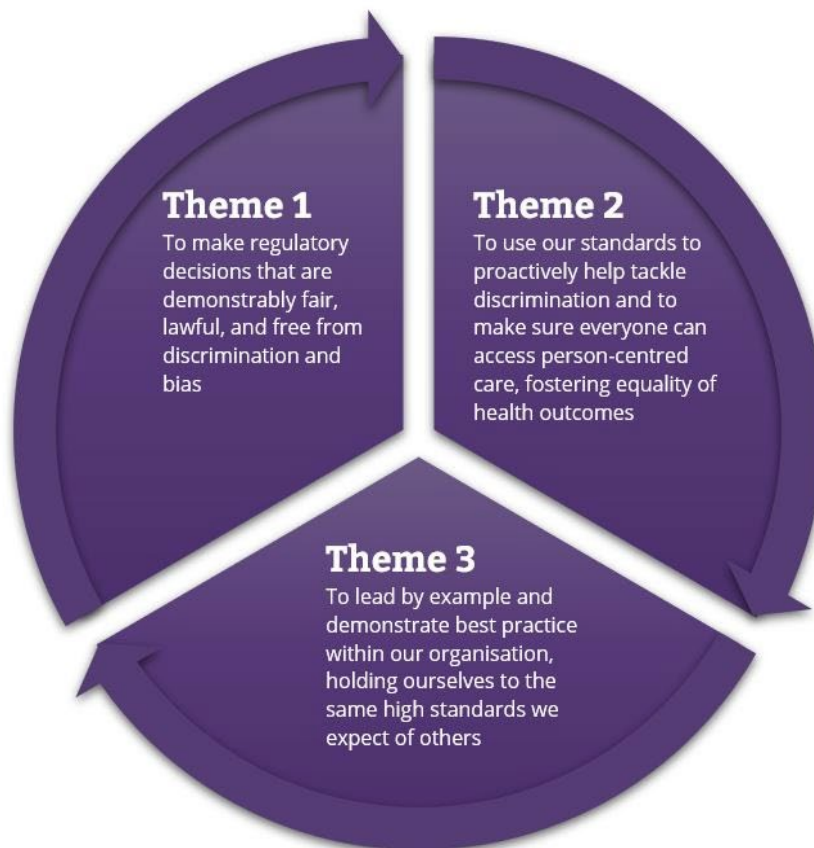
## Six month update (Year 1)

This report updates Council on key activity and progress we have made over the past six months, to support the delivery of our EDI strategic themes and objectives.

The reporting period covers quarter 1 and quarter 2, April to September 2022.

Figure 1 below illustrates the three strategic themes.

### Safe and effective pharmacy care at the heart of healthy communities



Overview of the main equality topics and issues that we have focused on in this period, through our activities as a regulator or employer



## **Theme 1: To make regulatory decisions which are demonstrably fair, lawful, and free from discrimination and bias**

### **SO1: Develop a new corporate approach to assess and improve the diversity data we collect from the professionals on our registers, our workforce and others, in line with best practice**

- Developed new and comprehensive diversity data principles and guidance, designed to support consistency when collecting, handling and analysing data across the GPhC and to align with external best practice on language and classification. This is due for final approval and roll out in Q3 and Q4.

### **SO2: Routinely publish diversity 'datasets' – including diversity data on fitness to practise cases – to support transparency, visibility and intelligence sharing**

- In June, we developed and published, for the first time, diversity datasets for our registers (pharmacists and pharmacy technicians), as well as specific diversity datasets for the three countries that we regulate.
- At the same time, we published supporting narrative and key messages to recognise and celebrate the diversity of the pharmacy professions on our registers and the range of benefits that this brings.
- Similar work has also begun to develop new diversity datasets linked to each part of our managing concerns process to support transparency, visibility and intelligence sharing.
- We will publish future reports to update this information, along with further analysis and trends as we start to develop our diversity data.
- In addition, we and other health and social care regulators are working with the PSA, as part of its programme of work in relation to its approach to equality, diversity and inclusion. We will be sharing data about the protected characteristics of professionals who are the subject of fitness to practise decisions. This will help the Professional Standards Authority (PSA) analyse its own decision-making in its section 29 work and whether this suggests that further work is needed in respect of training or other actions.

### **SO3: Use our diversity data to identify and monitor any disproportionate impacts on different groups, and to take steps to understand and deal with potentially discriminatory outcomes – for example, through initiatives such as anonymous decision-making pilots**

- Presented a detailed paper to Council in July on the work so far to minimise discrimination and bias in Fitness to Practise decision-making and our plans for additional reassurance, including looking at how to handle allegations of discrimination in concerns raised about pharmacy professionals.
- This included a detailed update and discussion with Council on the anonymous decision-making project, which begins in Q3.

**SO4: Support people to make non-discriminatory regulatory decisions, across all parts of our organisation, by having a new programme of equalities-related training sessions, including tailored sessions on different types of prejudice and discrimination**

- Reviewed and updated our Hearings and Outcomes guidance for Fitness to Practise committees to address how decision makers should consider concerns about discrimination, and how to take account of cultural factors when deciding on an outcome. We will engage with stakeholders on the updated guidance through a discussion paper in Q3.
- Developed new operational guidance on *“Dealing with concerns about antisemitism and Islamophobia: the use of working definitions and other resources in our investigations”*. This describes how matters are treated under the criminal law, the definitions and resources that should be considered when investigating concerns or allegations of this nature, and how these resources are used by other relevant bodies such as the Crown Prosecution Service.
- Following bespoke training on antisemitism for decision-makers (including statutory committee members and staff) at the end of last year, we are now planning similar training on Islamophobia for Q4.

**SO5: Take appropriate action when concerns are raised about discriminatory behaviour by pharmacy professionals, or about pharmacy education and training, getting relevant outside expert advice when we need to**

- Introduced several FtP process changes, to identify any potential issues around discriminatory behaviour on behalf of the referrer and establish if a referral is being used as a retaliatory measure. This includes:
  - **A check on whether the professional named in the concern has been referred to us before by the referrer** (i.e. the person raising the concern) to establish whether there are any potential issues around discriminatory behaviour on behalf of the referrer. This informs any action we will take in relation to the concern. There have been no multiple referrals identified since its introduction.
  - **A check on whether the professional has raised a concern internally in the period prior to being referred to the GPhC.** This helps us to establish whether a referral is being used as a retaliatory measure. This will inform any action we will take in relation to the concern. There have been none identified since its introduction.
  - **At the Oversight Review stage, we check for details of any other indication of potential discriminatory behaviour against the professional.** This review is conducted by a senior lawyer who decides, after we have completed initial assessment enquiries, whether the concern should be referred for investigation. The review includes a check for any discrimination in relation to the referral or any underlying discrimination within the concern that requires action. The purpose is to consider the context in which the concern was made as well as the specific facts of the case so that we can assess what is being said against what else might be going on. If any issues are identified, this will inform any action we take. No issues have been identified since the introduction of the review.

**Theme 2: To use our standards to proactively help tackle discrimination and to make sure everyone can access person-centred care, fostering equality of health outcomes**

**SO8: Develop comprehensive equality guidance for pharmacy owners, to support them in meeting their duties under the Equality Act and the Human Rights Act**

- Developed and consulted on new equality guidance for pharmacy owners (to be approved by Council at the November meeting).
- Conducted an additional public panel survey and developed a new report on the public's experience of pharmacy and any barriers to inclusive care. The survey was designed to give us a bigger picture of people's lived experiences when accessing pharmacy and healthcare. This is an important aspect of our EDI strategy, which sets out our commitment to improve the way we reflect and integrate lived experience and patient voice in all of our work.

**SO9: Support pharmacy technicians, pharmacists and pharmacy teams to provide person-centred care that recognises and respects diversity and cultural differences**

- At the beginning of the year, linked to our commitment to help reduce health inequalities, we developed an article with PANORAMIC – a UK-wide clinical study at Oxford University, looking at new **antiviral treatments for COVID-19**. This focused on the important role that pharmacy can play in supporting greater recruitment of volunteers from underserved and diverse backgrounds.
- In May, we published a new Regulate article on Sodium Valproate highlighting **patient safety risks for women and girls**, along with advice to professionals on how to dispense safely.
- Supported the launch of a new Pride in Practice resource from the LGBT Foundation **on inclusive care for LGBT+ patients**, which included our Chief Executive speaking at the launch event and sharing materials through our social media channels. We will be producing further work on LGBT+ inclusive care in due course.
- In April, we presented at an external roundtable on **disability in pharmacy**, to highlight our strategy and to discuss with other organisations the key issues affecting the profession such as accessibility and working environments.
- In September, we developed and published a new statement on how we **support people with reasonable adjustments** and other needs. This outlines how we take an inclusive approach to engaging with people (including the public and the professions we regulate) and recognises that we are all different and may have different needs.
- At the same time, we updated and reminded all GPhC staff about our expectations on how they should support people and published **top tips on how best to support people and listen to their needs**.
- In November, we designed and hosted a virtual roundtable **on racism in pharmacy** with the Chair of the NHS Race and Health Observatory, the President of the UK Black Pharmacist Association and other speakers, looking at how racism manifests in pharmacy and the resulting impact on patient care. We will be publishing a report of the roundtable and key actions in due course (to be covered in more detail in our next EDI update to Council).
- Continued to meet a range of external stakeholders working on different equality issues, to help inform our work. For example, we met with the Chair of the Cass Review into **Gender Identity**

**Services for Children and Young People**, specifically given the relevance to medicines and pharmacy regulation.

- Continued to **support the joint national Inclusive Pharmacy Practice Plan (IPP)**. Our Chief Executive sits on the Advisory Board and our Chief of Staff/Associate Director, Corporate Affairs sits on the supporting Improving Practice and Engagement Group. See SO10 below for details about the work we have done on cardiovascular disease to support the IPP initiative.

**SO10: Use our Knowledge Hub to promote and share examples of notable EDI practice that our inspectors have found during our inspections, to support the pharmacy team in continuous learning and improvement**

- To support the IPP work, we developed and published a case study about what pharmacy teams are doing to reduce health inequalities and support healthy living initiatives in their local communities, including interventions targeted at the risk factors associated with cardiovascular disease. This linked to the core theme of the IPP work in this period. The next theme is Diversity in Senior Pharmacy Professional Leadership, and we will be contributing to that work and reporting to Council on this at the end of Q4.

**SO11: Continue to make EDI a core part of our revised accreditation and quality assurance framework for pharmacy education and training. We will do this by strengthening our evidence framework and raising awareness of EDI themes through our accreditation reports**

- Continued work to ensure that revised and strengthened EDI standards are embedded in the delivery of courses by all education and training providers. We have now begun on schedule to accredit universities to the new initial education and training standards (due to be fully implemented by 2026), which includes strengthened requirements on EDI.
- All accreditation events include analyses of performance (final classifications and progression) by protected characteristics.
- Completed a supplementary equality impact assessment of the changes and mitigations introduced for the November 2022 sitting of the registration assessment, including reviewing all feedback received from candidates in relation to reasonable adjustments.

**SO12: Continue to meet our requirements under the Welsh Language Scheme and fully implement the new Welsh Language Standards when they are introduced**

- Held discussions with the Welsh Government, Welsh Language Commissioner and other healthcare regulators as we prepare for the Welsh Language Standards. We have begun individual meetings with the Commissioner to negotiate our compliance notice (the legal name for the regulations we will be bound to comply with), which is due in the latter part of the year.

**SO13: Proactively monitor external data, insights and reports on emerging EDI themes, including information about the experiences of the public and patients when accessing care, and we will improve the way we share these across the organisation to raise awareness and help shape our work**

- Produced the fourth edition of our new internal EDI Legal Insights Reports, to raise organisational awareness and competence on equalities and human rights issues happening the external context, and to identify any wider actions or learning points for the organisation. These are shared with the Senior Leadership Group for cascading to their directorates.
- Topics covered in our insights reports have included gender and non-binary discrimination, menopause support and women's health, religion, personal values and beliefs, prevention of sexual harassment in the workplace and conscientious objection and health policy.

### Theme 3: To lead by example and demonstrate best practice within our organisation, holding ourselves to the same high standards we expect of others

#### SO14: Carry out a learning needs analysis to spot gaps in the EDI knowledge of our workforce and implement a plan to put these right

- Following on from the completion of our organisation-wide EDI Learning Needs Analysis at the end of last year, we developed a co-ordinated EDI training plan for directorates across our organisation. (Mandatory inclusive leadership training was also undertaken by all senior leaders and managers last year, linked to the emergent findings of the LNA).
- In this period, we designed and piloted a new and more comprehensive 'Introduction to EDI' workshop, which has now been rolled out from Q1. This is now part of the induction process for all new joiners. A Q2 session is due to take place in November, and we shall review feedback as we progress.
- Fair selection training, also highlighted in the LNA, is planned to commence in Q3, aimed at all hiring managers. This will mean that going forward, all hiring managers will have the knowledge, skills and ability to apply best practice approaches to undertake inclusive interviews.
- Training on equality screening and impact assessments and our revised approach is planned for Q4. This will be supported by the new toolkit and revised template (see SO15 below).
- Following on from an away day in Q4 of last financial year which had a strong focus on EDI, the Insight, Intelligence and Inspection (III) Directorate held another in-person away day in Q1 to build on that work. This included three sessions on EDI:
  - The first was a session on **cultural competence** to benchmark current levels of understanding within the Directorate. Information from this session will inform next steps work in terms of increasing awareness and understanding within the Directorate.
  - The second session was delivered by one of the new specialist inspectors. This focused on better **understanding Islam** and featured a presentation by a local branch of the independent community pharmacy Imaan Healthcare, on their work in local communities to encourage minority groups to take up covid vaccinations.
  - Finally, there was an **LGBT+ awareness raising** session delivered by the LGBT Foundation, which is based in Manchester and runs the Pride in Practice programme with several healthcare professionals, including pharmacy.
  - In Q2, the III Directorate had a virtual, in-house awareness raising session on **Jewish culture and heritage**, led by a member of staff sharing lived experiences.
  - These resources are also now being shared with staff across the organisation, to support cultural competence and learning.

#### SO15: Update our corporate approach to equality impact assessments, developing new resources and training for our staff, and including lived experience in our assessments when we can

- Developed new and comprehensive Equality Screening and Impact Assessment (ESIA) guidance, toolkit and template. This is due for approval and roll out in Q3 and Q4.



- The revised toolkit, template and training are intended to raise awareness and provide staff with the knowledge and confidence required to undertake ESAs in a timely and confident way.
- This includes bespoke cases studies as well as new in-depth guidance on how to adopt an intersectional approach to assessments and how to use data and evidence effectively.

**SO16: Update the roles and responsibilities of our equality networks, to develop their capability and capacity and to help them contribute to better decision-making, by having a wider range of voices and experiences contributing to discussions**

- Last year, we conducted an all-staff survey, seeking views and opinions on the networks that staff wished to have in the organisation, including the support and level of commitment they could provide. The result of this engagement has resulted in the revival our new Employee Representative Group (ERG, under the remit of HR) and the set-up of a new Inclusion Network (IN, under the remit of EDI) earlier in the year.
- Throughout Q1 and Q2, activities have focused on agreeing governance arrangements and terms of reference for each group, electing Chairs and Co – Chairs, and in the case of the ERG, there has also been training facilitated by an external consultancy to support the development of the group.
- The IN has been critical in supporting the content for this year's Black History Month programme and members have also provided feedback on the new ESAs guidance and supporting materials.
- Notably, the Chair of the IN is a member of the EDI Strategic Leadership Group, which was agreed when the EDI Strategy was signed off as part of the governance arrangements. This reinforces the value of the role of the IN in terms of contributing to our strategic approach and provides a platform for staff views to be heard.

**SO17: Continue to take positive action to improve the opportunities and experiences of underrepresented groups within our staff, Council members, associates and partners, when appropriate**

- In June, we delivered a positive action workshop and training event for HR and EDI teams, to support the roll out of the new positive action guidance and strategic approach, previously approved by the Workforce Committee. This included learning through practical case studies and real examples.

**SO18: Continue to publish gender pay gap reports, and introduce ethnicity pay gap reporting. We will use the data to identify improvements in our processes and other action we need to take**

- Pay gap reports (gender and ethnicity) have been provided to our Workforce Committee and to a joint meeting with our Inclusion Network and Employee Representative Group, with discussion on action planning and next steps.
- Revised the pay award matrix so that junior staff (who are proportionately more diverse) are rewarded better.

**SO21: Adopt a more strategic approach to celebrating diversity dates, as part of our wider internal communications approach, and using these as a springboard to share interconnected messages about our wider work**



- Implemented our new EDI comms plan and published multiple blogs and insight pieces for all staff, to support inclusive workplace commitments. Council members have supported this work, including through sharing personal and lived experiences with our staff.
- In this period, eleven EDI pieces have been published on the internal InfoPoint on topics including age, disability (including hidden disabilities), religion or belief, sex/gender, and race. Some of the occurrences marked include Ramadan, Vaisakhi, Deaf Awareness Week, Pride and Black History Month. These blogs have provided the EDI team with the opportunity to update all staff on some key developments and strands of work and to raise awareness.
- Hosted one staff event to mark PRIDE month in June, led by an external speaker, who is a pharmacy student and President of the PDA LGBT+ Network.
- In this period, we also planned for our second staff event to mark Black History Month in October 2022 (this event will be reported in more detail in our next update covering Q3 and Q4).
- External communications have also aligned with the EDI comms plan, and a number of celebratory tweets have been posted on the GPhC external channels to showcase our commitment externally.

**SO22: Continue to meet Standard 3 of the Standards of Good Regulation set by the Professional Standards Authority (PSA). This sets the standard for all health and social care regulators in relation to equality, diversity and inclusion within regulation**

- We have met Standard 3 of Standards of Good Regulation in this year's review. However, we are not complacent and are contributing to ongoing discussions with the PSA and other regulators about how the assessment of this standard may evolve in the future.

**SO24: Assess and agree additional external standards that we will work towards in the future**

- Applied for external benchmarking/assessment with MIND and achieved Silver Accreditation in the Workplace Wellbeing Index. This shows that we are making demonstrable progress in promoting staff mental health and wellbeing, taking action across several key areas, and demonstrating impact over time.
- Set up a staff working group, under the Employee Representative Group, to take forward the MIND recommendations and develop and deliver a supporting Action Plan.

# GPhC equality guidance

## Meeting paper for Council on 10 November 2022

Public business

### Purpose

To provide Council with the analysis report on the draft equality guidance consultation, together with the revised guidance.

### Recommendations

The Council is asked to note:

- the analysis of the responses to the draft equality guidance (Appendix 1)
- the analysis of the responses to the online public panel member survey (Appendix 2)

The Council is asked to approve:

- the revised guidance which incorporates feedback from the consultation (Appendix 3)

## 1. Introduction

1.1 Between 7 April and 6 June 2022, we consulted on our draft equality guidance for pharmacies; an entirely new piece of guidance, which is designed to support pharmacy owners and their teams to understand and meet the standards for registered pharmacies and the requirements set out under the Equality Act 2010.

1.2 The draft guidance will also help pharmacy owners to:

- help protect the rights of individuals
- advance equal opportunity for staff, patients, and the wider public, and
- improve the experience and healthcare outcomes of patients and members of the public using their pharmacy's services.

1.3 We received a total of 190 written responses to our consultation; 172 of these respondents identified themselves as individuals and 18 responded on behalf of an organisation. A full analysis of responses is included in Appendix 1.

1.4 This paper provides an overview of what we heard in response to the consultation and how the feedback we received has helped shape the revised guidance.

## 2. Background

2.1 We have a legal duty, under the Equality Act, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity

between people from different groups, and foster good relations between people from different groups when carrying out all our day-to-day functions and activities as a public body.

- 2.2 Our delivering equality, improving diversity and fostering inclusion (EDI) strategy (**Our strategy for change 2021–26**) sets out our intentions, and commitment, which includes the development of a comprehensive equality guidance for pharmacy owners.
- 2.3 The equality guidance will deliver on our objective under Theme 2 of the EDI Strategy, which relates to the use of our standards to proactively help tackle discrimination and to make sure everyone can access person-centred care, fostering equality of health outcomes.
- 2.4 To develop the guidance, we took note of the earlier feedback from the consultation on the EDI strategy, and held internal and external workshops with our stakeholders which focused on the equality guidance. The guidance also takes account of feedback from Council at an earlier workshop.
- 2.5 As part of the consultation, we also conducted a survey of our online public panel members. This survey was open from 27 April to 6 June 2022. We received 63 responses to the online public panel member survey and the findings of this survey have been written up in a separate report (which can be found in Appendix 2).
- 2.6 Our consultation and online survey asked for views on understanding and applying the guidance; the areas covered in the guidance; and the impact of the guidance.

### **3. Summary of responses to the consultation**

#### **Understanding and applying the guidance**

- 3.1 Overall, a large majority of respondents felt that the structure and language of the guidance was easy to understand and almost two-thirds of all respondents thought that the guidance was easy to apply.
- 3.2 Despite this, respondents who left open-ended comments held mixed views on the structure and language of the guidance. Those who spoke positively about the guidance explained that it was clear, well-structured, and easy to understand. The examples and case studies highlighted throughout the guidance were also well-received and drew recognition from many respondents.
- 3.3 On the other hand, some respondents felt that structure of the guidance was lengthy and overly complex, whilst others questioned how it would be applied in practice and called for more detail to reinforce the examples/case studies.
- 3.4 Several respondents also put forward suggestions on how the guidance could be improved and identified specific areas that may require further attention. For example, the provision of additional, or more detailed, examples.

#### **The areas covered in the guidance**

- 3.5 Half of all respondents did not believe we had missed out anything important. However, more individuals (51%) held this view compared to organisational respondents (39%).
- 3.6 Many respondents put forward several suggestions on areas that they thought were missing in the guidance. Most respondents focused on minority groups or individuals that would be impacted by the guidance but had not been explicitly mentioned in the guidance itself.

- 3.7 Similarly, some respondents also felt that there were groups or individuals that the guidance should focus more on such as employees or staff and the impact the proposals would have on them specifically.
- 3.8 Many respondents used this section to make suggestions on how the guidance could be improved more generally, for example changes to the terminology so that it is more inclusive.

#### **Impact of the guidance**

- 3.9 Many respondents held positive views on the impact of the guidance but those who explained in more detail felt that the guidance would lead to service improvements for patients and would also provide better support and protection for staff. Conversely, many respondents were concerned that the guidance was merely a tick-box exercise and that no net benefit would be felt once the guidance was introduced. A similar proportion of respondents thought that the guidance would increase the burden on staff and owners as they attempt to meet and comply with the requirements.

### **4. Equality guidance updates**

- 4.1 The Equality guidance has been revised using feedback from the consultation. The revised guidance can be found in Appendix 1.
- 4.2 Changes include:
  - a) Updated terminology. For example, the use of the term 'BAME' (Black, Asian and minority ethnic) has been found by the Government Equalities Office to be unhelpful and should be dropped. They instead advocate a focus on understanding disparities and outcomes for specific ethnic groups.
  - b) Further detail has been included to help overcome language barriers, for example, through targeted and better-informed use of primary care and public health services and prevention initiatives. Further clarity has also been included on the risks that should be considered and managed when using other mechanisms, such as pharmacy staff, to overcome language barriers.
  - c) The findings from the online public panel member survey have been included as an Annex in the guidance. These real examples from service users will help pharmacy owners and pharmacy staff understand the impact service delivery has on people, and how outcomes can be improved.
  - d) Additional reference sources have been included, for example further background information on Equality Impact Assessments (EIAs).

### **5. Equality and diversity implications**

- 5.1 When developing our guidance, we have considered whether there are any significant equality implications, either positive or negative, for registrants or members of the public. We have not identified any significant negative equality or diversity implications of our proposals and expect there to be a positive benefit for patients and the public.
- 5.2 The consultation provided an opportunity for respondents to provide feedback on any equality or diversity issues they wished to raise. Most respondents felt that our proposals would have a positive impact on groups or individuals who share any of the nine protected

characteristics. Many respondents (59%) felt that the guidance would have the largest positive impact for disabled people.

- 5.3 Section 3 of the report at Annex A sets out responses on the impact of the changes based on protected characteristics. Overall, the majority of respondents believed there would be no particular impact or a positive impact based on the protected characteristics.

## **6. Communications**

- 6.1 This report will be published on our website.
- 6.2 The new equality guidance is expected to be published later in 2022, subject to Council approval. We will share the new guidance with pharmacy owners and all other key audiences through targeted emails, Regulate (our regular e-bulletin), the pharmacy trade press, presentations and talks, social media and through other networks.

## **7. Resource implications**

- 7.1 The resource implications for this work have been accounted for in existing budgets.

## **8. Risk implications**

- 8.1 In our EDI strategy we have committed to develop a comprehensive equality guidance for pharmacies. The guidance will help to foster equality of health outcomes by proactively helping to tackle discrimination and promote access to person-centred care for everyone.

## **9. Monitoring and review**

- 9.1 The Equality guidance, once approved, will be reviewed according to the normal review cycle or earlier if needed.

## **10. Recommendations**

The Council is asked to note:

- the analysis of the responses to the draft equality guidance (Appendix 1)
- the analysis of the responses to the online public panel member survey (Appendix 2)

The Council is asked to approve:

- the revised guidance which incorporates feedback from the consultation (Appendix 3)

Annette Ashley, Head of Policy and Standards  
General Pharmaceutical Council

Tejal Davda, Policy Manager (Standards)  
General Pharmaceutical Council

19/10/2022

# Consultation on draft equality guidance for pharmacies: analysis report

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# Executive summary

## Background

Between 7 April and 6 June 2022, we consulted on our draft equality guidance for pharmacies; an entirely new piece of guidance, which is designed to support pharmacy owners in understanding and meeting the standards for registered pharmacies.

The draft equality guidance is organised along the lines of the five principles in **the standards for registered pharmacies**. It covers a variety of topics underneath each of the principles and introduces some of the principles of the **Equality Act 2010** that pharmacy owners must take account of, including:

- the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation)
- the ‘duty to make reasonable adjustments’ to the property from which services are provided, to meet the needs of people with disabilities (including patients, service users and employees)
- the duty to remove discrimination, harassment, and victimisation

The draft equality guidance also includes several examples of good practice, taken from the GPhC Knowledge Hub and our inspections. These examples are intended to encourage and support pharmacy owners and pharmacy staff to think about the needs of the patients and the public in their communities, and how they can continue to develop the services they provide.

We delivered this consultation through a consultation survey which received **190** responses: **172** from individuals and **18** on behalf of an organisation.

## Key issues raised in responses

### Views on understanding and applying the guidance

In general, respondents were optimistic that the guidance was easy to understand and apply. When asked to consider the structure and language of the guidance, over three-quarters of all respondents (78%) thought that it was easy to understand. Whilst still agreeing, a slightly smaller percentage of respondents (61%) felt that the guidance would be easy to apply.

When asked to explain their comments, many respondents thought that the guidance was well-structured, clear, and easy to follow which would also make applying the guidance more straightforward. The inclusion of the examples and case studies were well received throughout and drew favourable comments from several respondents. Some respondents also gave suggestions on how the examples could be strengthened further. Those who held less favourable views on the guidance argued that the structure of the guidance was lengthy and overly complex, whilst others questioned how it would be applied in practice. Several respondents suggested changes to the guidance, and identified areas that they thought may require further attention.

### Views on the areas covered in the guidance

When asked to think about the areas covered in the guidance, half (50%) of all respondents did not think we had missed out anything important. However, a quarter of respondents (25%) felt that there were aspects missing and were asked for further comments. Most respondents focused on minority groups or

individuals that would be impacted by the guidance but had not been explicitly mentioned in the guidance itself, e.g., refugees, those with caring responsibilities, etc. Similarly, some respondents also felt that there were groups or individuals that the guidance should focus more on such as employees or staff and the impact the proposals would have on them specifically. Many respondents used this section to make suggestions on how the guidance could be improved, for example changes to the terminology so that it is more inclusive.

### **Views on the impact of the proposals**

Most respondents (50% to 59%) felt that our proposals would have a positive impact on groups or individuals who share any of the nine protected characteristics. Similarly, many respondents thought that the proposals would have a positive impact on patients and the public (53%), and pharmacy staff (49%). However, slightly fewer respondents felt that pharmacy owners would be positively impacted by the proposals (40%). Some respondents were concerned that complying with the guidance could adversely impact staff and employees as it would create an additional burden.

Some respondents thought that guidance could lead to service improvements for patients as pharmacies become more inclusive places, whilst others thought that the proposals would also provide better support and protection for staff. Conversely, many respondents were concerned that the guidance was merely a tick-box exercise and that no net benefit would be felt once the guidance was introduced.

# Introduction

## Policy background

The GPhC is committed to delivering equality, improving diversity and being inclusive. We have a legal duty, under the Equality Act, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between people from different groups, and foster good relations between people from different groups when carrying out all our day-to-day functions and activities as a public body.

Our newly published **Delivering equality, improving diversity and fostering inclusion (Our strategy for change 2021–26) (EDI strategy)** sets out our intentions, and commitment, which includes the development of comprehensive equality guidance for pharmacy owners.

The equality guidance will deliver on our objective under Theme 2 of the EDI Strategy, which relates to the use of our standards to proactively help tackle discrimination and to make sure everyone can access person-centred care, fostering equality of health outcomes.

All pharmacy owners must meet their legal responsibilities as well as meeting our standards. The guidance does not list the legal duties under the Equality Act 2010 and the Human Rights Act 1998. Those legal requirements, as well as our standards, are already in place and pharmacy owners should already be aware of their obligations. This guidance is a reminder of the various areas pharmacy owners should consider in their work and, through the use of good practice examples, encourages them to consider the specific needs of their staff, as well as patients and the public.

For more detail on the changes we are proposing, see [Appendix 1: Summary of our proposals](#).

# Analysis of consultation responses

In this section of the report, the tables show the level of agreement/disagreement of survey respondents to our proposed changes. In each column, the number of respondents ('N') and their percentage (%) is shown. The last column in each table captures the views of all survey respondents ('Total N and %'). The responses of individuals and organisations are also shown separately to enable any trends to be identified.

NB. See [Appendix 2: About the consultation](#) for details of the consultation survey and the number of responses we received, [Appendix 3: Our approach to analysis and reporting](#) for full details of the methods used, [Appendix 4: Respondent profile](#) for a breakdown of who we heard from, and [Appendix 5: Organisations](#) for a list of organisations who responded. [Appendix 6: Consultation questions](#) contains a full list of the questions asked in the consultation survey.

## 1. Understanding and applying the guidance

**Table 1:** Views on how easy the guidance is to understand (Base: All respondents)

<b>Q1. Thinking about the structure and language of the guidance, do you think it is easy to understand?</b>	<b>N and % individuals</b>	<b>N and % organisations</b>	<b>N and % Total</b>
<b>Yes</b>	133 (77%)	15 (83%)	148 (78%)
<b>No</b>	26 (15%)	3 (17%)	29 (15%)
<b>Don't know</b>	13 (8%)	0 (0%)	13 (7%)
<b>Total N and % of responses</b>	<b>172 (100%)</b>	<b>18 (100%)</b>	<b>190 (100%)</b>

**Table 2:** Views on how easy the guidance is to apply (Base: All respondents)

<b>Q2. Thinking about the structure and language of the guidance, do you think it is easy to apply?</b>	<b>N and % individuals</b>	<b>N and % organisations</b>	<b>N and % Total</b>
<b>Yes</b>	105 (61%)	10 (56%)	115 (61%)
<b>No</b>	37 (22%)	7 (39%)	44 (23%)
<b>Don't know</b>	30 (17%)	1 (6%)	31 (16%)
<b>Total N and % of responses</b>	<b>172 (100%)</b>	<b>18 (100%)</b>	<b>190 (100%)</b>

Overall, a large majority (78%) of respondents felt that the structure and language of the guidance was easy to understand. Those that shared this view included slightly more organisational respondents (83%) than individuals (77%). In contrast, table 1 shows that far fewer respondents (15%) including a similar

number of individual (15%) and organisational respondents (17%), did not think the guidance was easy to understand. A small percentage of respondents (7%), all of whom were individuals, stated that they did not know whether the guidance was easy to understand.

In response to question 2, almost two-thirds (61%) of all respondents thought that the guidance was easy to apply. However, slightly fewer organisations (56%) shared this view compared to individuals (61%). As highlighted in table 2, around a quarter of all respondents (23%) did not think the guidance was easy to apply, including a higher percentage of organisations (39%) than individuals (22%). Of the 16% of respondents who did not know whether the guidance was easy to apply, only one identified as an organisation.

Around three-fifths of all respondents left explanatory comments. Set out below is an analysis of the themes found in their responses.

### **1.1. Summary of themes**

Respondents who left open-ended comments to this question held mixed views on the structure and language of the guidance. Those who spoke positively about the guidance explained that it was clear, well-structured, and easy to understand. The examples highlighted throughout the guidance were also well-received and drew recognition from many respondents. Despite this, some respondents felt that structure of the guidance was lengthy and overly complex, whilst others questioned how it would be applied in practice and called for more detail to reinforce the examples included. Several respondents also put forward suggestions on how the guidance could be improved and identified specific areas that may require further attention.

The analysis below sets out the themes that emerged from the responses. The themes, in order of prevalence, were:

- The guidance is well structured, clear, and easy to follow
- The examples of good practice are a helpful resource
- Difficulties in applying the guidance in practice, and more examples required
- The structure of the guidance is lengthy and overly complex
- The language used in the guidance is vague and unclear
- The guidance is straightforward to apply and implement
- Specific wording changes/corrections
- Other comments

### **1.2. The guidance is well structured, clear, and easy to follow**

The most common theme to emerge from respondents was that the guidance is well structured, clear, and easy to follow. For those who gave specific comments, some welcomed the approach in aligning the guidance with the five principles in the standards for registered pharmacies as it highlighted the link between the two and made it easier to interpret. Commenting on the tone, some respondents felt that the guidance struck the right balance between identifying the legal considerations that owners should be aware of, and the best practice examples that underpin them. Similarly, a few respondents thought that the language and wording used throughout was simple and therefore easy to understand, whilst others felt that the explanation of some of the more complex terms and signposting to other relevant resources were helpful inclusions.

### **1.3. The examples of good practice are a helpful resource**

The good practice examples used throughout the guidance to demonstrate how some pharmacies have met their equality duties were well received. Many respondents felt that the examples brought the guidance to life and broke down a subject that was sometimes complex and challenging. A few respondents also thought that the examples could inspire pharmacy owners to consider how they can meet their own equality requirements, whilst also encouraging shared learning more generally. Commenting on how the examples were presented, a few respondents found them to be of an appropriate length and which did not detract from the guidance.

### **1.4. Difficulties in applying the guidance, and more examples required**

The most common aspect that respondents felt needed further attention was how the guidance would be applied in practice. Respondents thought that the guidance was too rigid and did not consider the challenges and nuances that different types of registered pharmacies face. A few respondents highlighted the time constraints and limited resources experienced by some smaller pharmacies compared to larger multiples. There were also concerns that when addressing the guidance, some owners would treat it as a tick-box exercise. A limited number of respondents felt that the broad concept behind the guidance was difficult to grasp and therefore implement.

Commenting on specific aspects of the guidance, a few respondents thought that references to Equality Impact Assessments (EIAs) required more detail to enable pharmacy owners to apply these in practice. There were concerns that smaller community pharmacies would be less familiar with EIAs and their purpose whilst some respondents called for EIAs to be worked into one of the examples so that it is easier to understand.

Some respondents had reservations about the examples used throughout the guidance and felt that they needed to be expanded, whilst others felt that more examples would be helpful to support owners in meeting their requirements.

A few respondents were concerned that the guidance was solely aimed at community pharmacies and did not consider any other settings such as hospital pharmacies, which face different challenges from an equality perspective. Given the emergence of new types of pharmacy services in recent years, there were calls by a small number of respondents to keep the guidance updated at regular intervals to ensure that it remains operational and effective.

### **1.5. The structure of the guidance is lengthy and overly complex**

Commenting on the structure of the guidance, many respondents were concerned that it was overly complex or too lengthy. These respondents felt that there was too much information which could dilute the key messages. More specifically, a few respondents thought that the guidance could be reduced into a 'bitesize' or simpler format to avoid repetition or unnecessary confusion for owners when applying the guidance.

### **1.6. The language used in the guidance is vague and unclear**

A few respondents took issue with the language used throughout the guidance and thought that some aspects were unclear. Although they did not give specific examples, some respondents thought that the language was either too vague and needed to be simpler, or too complex in some areas. A few respondents felt that the guidance could be strengthened so that the responsibilities for the pharmacy owner are set out more clearly.

### 1.7. Specific wording changes/corrections

In addition to the themes highlighted above, some respondents provided comments on specific content or text and recommended changes that would improve the guidance. A sample of these are highlighted below:

- A few respondents drew attention to the examples in the guidance and highlighted where improvements or amendments could be made to ensure that they remain accurate and reflect the key messaging in the guidance. An organisation raised concerns that the guidance gave some very specific examples which could be interpreted as being the only situations where those issues could arise.
- A small number of respondents felt that some general statements in the guidance needed to be qualified or explained further so that the reader understands why equality is important.
- A few organisational respondents felt that some of the terms used in the guidance required an update. For example, it was noted by an organisational respondent that the term 'people with disabilities' is an outdated term and that 'disabled people' is more appropriate. Furthermore, a respondent also explained that the term BAME is outdated and should be avoided.
- It was noted by a respondent that safeguarding issues can be prevalent in all aspects of society regardless of protected characteristics and that the guidance should reflect this.

### 1.8. The guidance is straightforward to apply and implement

In support of the guidance, some respondents thought that it would be straightforward to apply and implement. Most of these respondents cited the structure and clarity of the guidance as the main reasons (see section 1.2) and thought that aligning the guidance with the principles in the standards for registered pharmacies would be beneficial in helping owners to apply the guidance. A few respondents also thought that the examples included throughout the guidance were helpful in making sure that the guidance is implemented as it was intended. Despite this, views on how the guidance could be applied in practice were more mixed and some respondents also raised concerns on how easy the guidance would be to implement (see section 1.4).

### 1.9. Other comments

Alongside the themes already explored in this section, respondents raised several other points which are captured below, in order of frequency.

- Respondents put forward several suggestions or areas that they felt were either missing or required more detail in the guidance. Please refer to section 2.3 of the report for further details.
- Some respondents questioned how the GPhC could enforce the guidance, citing the vagueness of the guidance, which would make it difficult to impose or police. A few organisational respondents suggested that the guidance could be aligned with the inspection framework so that the GPhC could monitor how it is being enforced.
- A small number of respondents were critical of the GPhC more generally, with some arguing that the cost in developing the guidance could be better spent elsewhere.
- A few respondents considered the impact of the guidance and what groups may be positively or negatively impacted by the proposals (see section 3).

## 2. Areas covered in the guidance

**Table 3:** Views on whether we have missed anything important in the guidance (Base: All respondents)

Q4. Thinking about the areas covered in the guidance, do you think we have missed out anything important?	N and % individuals	N and % organisations	N and % Total
Yes	37 (22%)	11 (61%)	48 (25%)
No	88 (51%)	7 (39%)	95 (50%)
Don't know	47 (27%)	0 (0%)	47 (25%)
Total N and % of responses	172 (100%)	18 (100%)	190 (100%)

When asked to think about the areas covered in the guidance, table 3 shows that half of all respondents (50%) did not believe we had missed out anything important. However, more individuals (51%) held this view compared to organisational respondents (39%). A quarter of all respondents (25%) felt that there were aspects in the guidance that were missing including a much higher proportion of organisations (61%) than individuals (22%). A quarter of all respondents (25%), all of whom were individuals did not know if there were any areas missing in the guidance.

Those who responded 'yes' were asked for further comments and just under a quarter of respondents left explanatory comments to this question. The following is an analysis of the themes found in these comments.

### 2.1. Summary of themes

Respondents to this question put forward several suggestions on areas that were missing in the guidance. Whilst many respondents focused more generally on aspects that they felt were missing or required more detail, others highlighted specific minority groups or individuals which the guidance had not addressed, for example carers and asylum seekers. Similarly, some respondents felt that there were groups or individuals mentioned in the guidance which required greater emphasis, or needed to be covered in more detail.

Many respondents put forward suggestions on how the guidance could be improved or changed so that it remains accurate and up to date. A few respondents also felt that more detailed examples would be helpful or that further information was required on how to implement the guidance. A small number of respondents highlighted some specific training or knowledge gaps that would help supplement and reinforce the guidance.

The analysis below sets out the themes that emerged from the responses, in order of prevalence, as follows:

- There are specific minority groups missing or not referenced in the guidance
- Other areas requiring inclusion or more detail
- Specific wording changes/corrections
- Groups requiring more detail/emphasis



- More examples needed
- More information required on implementing the guidance
- Training/knowledge related gaps
- Other comments

## 2.2. There are specific minority groups missing or not referenced in the guidance

The most common theme to emerge from this question was that there were specific minority groups or individuals that should be included in the guidance. The most common group that respondents felt was missing were those with hidden disabilities such as mental health conditions, including autism or dyslexia. A few respondents also felt that the guidance should consider refugees or immigrant families from all backgrounds. The following groups were also briefly mentioned by a small number of respondents:

- People with English as a second language
- Carers
- Non-resident single fathers
- Those in poverty or homeless
- People who use British Sign Language

## 2.3. Other areas requiring more inclusion or detail

Aside from identifying specific groups or individuals missing in the guidance, many respondents, including a higher proportion of organisational respondents than individuals, put forward suggestions for other areas that the guidance could include or could address in more detail.

A few respondents felt that the guidance could include references to translation services to ensure that pharmacies are accessible to all, including those with different language requirements. It was also noted by a very small number of respondents that the labelling of medicines could reflect these requirements, for example labels printed in Welsh as well as English.

Whilst recognising that the GPhC does not have jurisdiction over premises they do not regulate, a few organisational respondents thought that the guidance could be re-framed so that it is aimed at pharmacy professionals as well as pharmacy owners. By broadening the reach of the guidance, these respondents felt that it could support wider improvements in patient care. The following issues were also briefly referenced:

- A very small number of respondents felt that the guidance could emphasise the importance of digital accessibility when considering equality more widely. For example, an organisation felt that reference to the Public Sector Body Website Accessibility Regulations in the guidance would allow online pharmacies to know specifically what to aim for when meeting their accessibility requirements from a digital technology perspective.
- A limited number of respondents thought that the guidance could emphasise the importance of partnership working when pharmacies consider how to meet their equality requirements. For example, it was suggested that the guidance could highlight the close relationship between pharmacies and the NHS more widely and the importance of managing this relationship carefully to meet equality requirements for patients.

- An organisation explained that pharmacies should prioritise those with lived experience and should consult with the local community groups that represent impacted people when developing strategies or plans on equality.
- An organisation felt that the guidance could be strengthened so that there is greater emphasis on the importance of risk assessments to help identify any equality gaps at each registered pharmacy.

## 2.4. Specific wording changes/corrections

A small number of respondents, including a higher proportion of organisations than individuals, put forward specific wording changes that they felt were required in the guidance. For example, in the introduction a few respondents thought that the guidance should be reframed slightly so that it is more inclusive for everyone not just for those with protected characteristics. A very small number of respondents thought that some of the examples would sit more appropriately in a different section of the guidance. A similar number of respondents felt that the 'other useful sources of information' section may need revising to ensure that the organisations listed are appropriate, whilst others were of the view that the guidance could signpost people to other relevant sources of information not already included. Please also refer to section 1.7 for further information.

## 2.5. Groups requiring more detail/emphasis

Some respondents thought that the groups of people referenced throughout the guidance could be expanded or revised. The most common group that respondents felt required more detail were staff who worked in pharmacies. Many respondents who shared this view argued that the guidance was too focused on patients/the public and less so on staff. Going into more detail, they explained that guidance could address the pharmacy owner's role in relation to some of the equality issues faced by staff. For example, a few respondents thought that the guidance could include the following:

- having sufficient staffing levels in place
- consider the needs of staff when considering the working environment and accessibility of the pharmacy environment
- appropriately trained staff to deal with complex equality issues
- staff remuneration
- the wellbeing of staff and ensuring that they are protected

Some respondents also highlighted issues affecting other groups which may require further attention or explanation in the guidance. These include:

- age discrimination
- sexuality, including the wider scope of sexuality
- women who are subject to prejudicial cultural practices
- women who are experiencing menopause
- pharmacy owners, i.e. the principles covered in the guidance should apply to pharmacy owners who should also be treated fairly

## 2.6. More examples needed

Although the examples in the guidance were praised by many respondents, a small number felt that they could be revised to maximise their benefit. On this, a few respondents felt that the examples could focus on more of the complex areas where pharmacy owners may need further support, for example where the interests of those with protected characteristics clash with those of others with the same or different protected characteristics. It was noted by a very small number of respondents that an example or case study could sit under many of the principles in the standards for registered pharmacy rather than only one, as it is currently.

## 2.7. More information required on implementing the guidance

A small number of respondents indicated that the guidance required further information on how it is intended to be applied in practice from a procedural perspective. Explaining further, these respondents felt that the guidance could be improved if there was more detail on how concerns relating to equality can be raised by both staff and the public, and how owners are expected to document or resolve such issues when they do arise. A respondent also felt that the guidance should signpost or refer to resources that are applicable in Scotland and Wales rather than focusing on England exclusively.

## 2.8. Training/knowledge related gaps

A handful of respondents felt that appropriate training should be provided to staff to reinforce some of the main principles highlighted in the guidance. It was suggested that the guidance could make explicit reference to this, including what type of training is appropriate, when it is required and expectations for staff and owners in undertaking this. A few respondents thought that providing mandatory training for new starters and refresher training for existing staff on equality issues would be helpful. Furthermore, a small number of respondents highlighted specific areas where training was required, e.g. training on managing a dispute with a patient, healthcare professional or member of the public on an equality issue.

## 2.9. Other comments

Respondents raised several other points not already mentioned which are captured below, in order of frequency.

- A small number of respondents were generally critical of the GPhC without providing much context.
- A few respondents queried how the guidance would be enforced and how it would align with the GPhC's inspection function (please refer to section 1)
- A respondent warned that financial support from the NHS was required to achieve the objectives set out in the guidance.
- A respondent felt that some pharmacies may not have the means to offer a reasonable adjustment in a safe and proportionate manner. They called for more guidance on what to do in these scenarios.

### 3. The impact of the proposed changes

**Figure 1:** Views of all respondents (N = 190) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

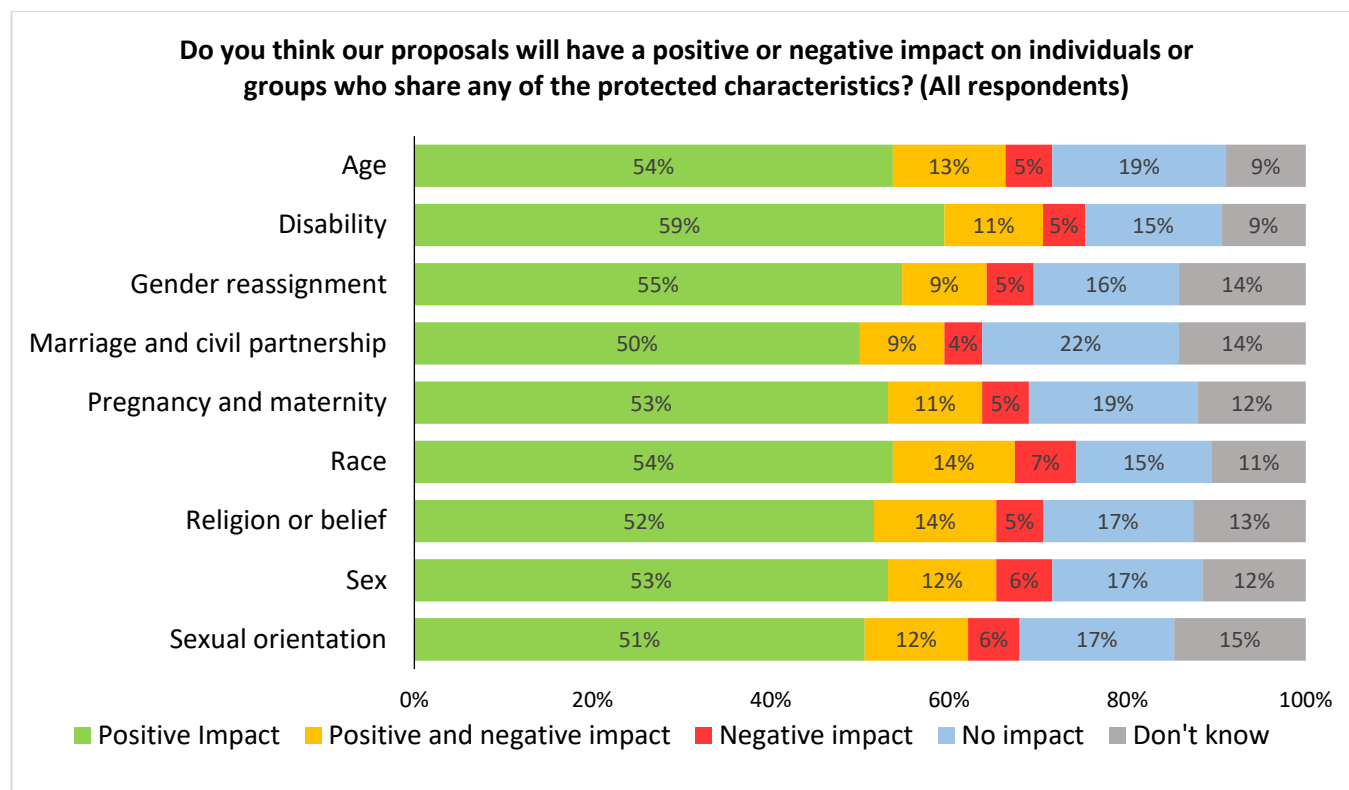


Figure 1 shows that most respondents (ranging from 50% to 59%) felt that our proposals would have a positive impact on groups or individuals who share one or more of the nine protected characteristics. The protected characteristic that respondents thought would have the largest positive impact was disability (59%).

A small number of respondents (ranging from 15% to 19%) thought that proposals would have no impact on each of the protected characteristics, except for marriage and civil partnership, where almost a quarter (22%) of respondents selected 'no impact'.

Only a very small proportion of respondents (between 4% and 7%) felt that the proposals would have a negative impact on people sharing one or more of the nine protected characteristics, with race (7%) scoring the highest in this category. Slightly more respondents (ranging from 9% to 14%) indicated that the proposals would have both a positive and negative impact on all the protected characteristics.

Across all the protected characteristics, a modest proportion of respondents (between 9% and 15%) did not know what the impact of the proposals would be.

A full breakdown of individual and organisational responses to this question is available in [Appendix 7](#).

**Figure 2:** Views of all respondents (N = 190) on whether our proposals positively or negatively impact any other individuals or groups

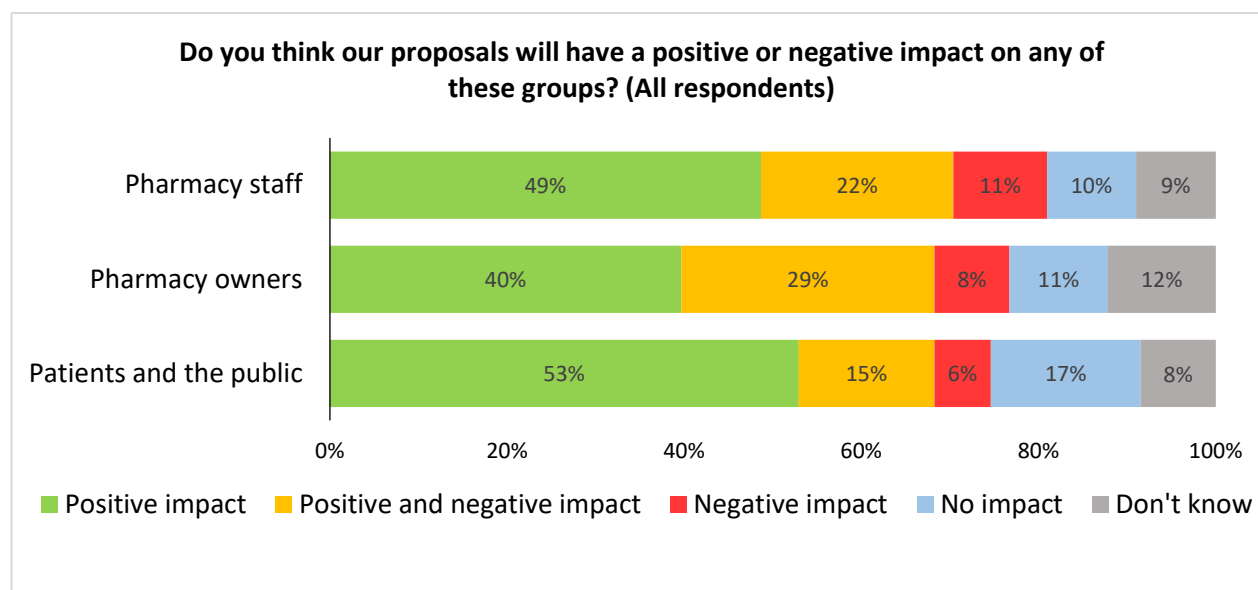


Figure 2 shows that many respondents thought that the proposals would have a positive impact on patients and the public (53%). Slightly fewer respondents felt that pharmacy staff (49%) and pharmacy owners (40%) would be positively impacted by the proposals. In contrast, a smaller but similar proportion of respondents (between 8% and 11%) thought that the proposals would have a negative impact, with pharmacy staff (11%) scoring the highest.

A modest proportion of respondents (ranging from 15% to 29%) indicated that the proposals would have both a positive and negative impact on the groups identified above. Slightly more respondents thought the proposals would have no impact on patients and the public (17%) compared to pharmacy owners (11%) and pharmacy staff (10%).

More respondents indicated they did not know how the proposals would impact pharmacy owners (12%) compared to pharmacy staff (9%) and patients and the public (8%).

A full breakdown of individual and organisational responses to this question is available in [Appendix 8](#).

Just over half of all respondents left explanatory comments on the impact of the proposals. Set out below is an analysis of the themes found in their responses.

### 3.1. Summary of themes

Respondents submitted mixed views in the comments to the impact questions. Many respondents held positive views on the impact of the guidance; those who explained in more detail felt that the guidance would lead to service improvements for patients and would also provide better support and protection for staff. However, many respondents were concerned that the guidance was merely a tick-box exercise and that no net benefit would be felt once the guidance was introduced. A similar proportion of respondents thought that the guidance would increase the burden on staff and owners as they attempt to meet and comply with the requirements. Some respondents held more neutral views and felt that the concept and broad themes covered in the guidance meant that it would be difficult to assess its impact more widely. Similarly, a smaller number of respondents felt that the guidance would need time to embed before the impact of any changes could be assessed or reviewed.

Set out below are the themes found in the responses to the impact questions, in order of prevalence, as listed below:

- General positive impact
- Service improvement for patients
- No discernible impact
- Additional work and burden complying with the guidance
- Better protection and support for pharmacy staff
- The guidance is subjective and divisive
- The guidance will benefit owners
- Time required to assess the impact

### **3.2. General positive impact**

Many respondents held positive views on the impact of the guidance. This was the most prevalent theme from the comments in this section. Whilst they did not go into detail, there was a general indication amongst respondents that the guidance was a step in the right direction in promoting equality in pharmacies. Focusing on the impact, most of these respondents felt that all groups or individuals would benefit from the guidance, as it would place a greater emphasis on owners to consider how they can meet their equality duties. At a minimum, a few respondents thought that the guidance would increase awareness of equality legislation, which was positive.

### **3.3. Service improvements for patients**

Many respondents spoke positively of the impact that the guidance would have on patients and the public. Specifically, respondents highlighted the service improvements that patients would experience if the guidance was followed. Some respondents gave suggestions on where these service improvements would be most visible. For example, a few respondents thought that pharmacies would become more inclusive and accessible places and that barriers would be reduced for patients and the public in accessing the services they require. Most respondents who shared this view felt that the guidance would encourage owners and pharmacy professionals to think more carefully how they can be more person-centred.

### **3.4. No discernible impact**

Many respondents were concerned that there would be no discernible impact resulting from the guidance. Explaining why, they warned that the guidance was merely a tick-box exercise that would make little or no difference in practice. It was also suggested by a few respondents that pharmacies were already aware and complying with their equality duties and that the guidance was unnecessary. A small number of respondents noted that patients and the public would not notice any obvious and tangible difference once the guidance was in place as the Equality Act already provided them with sufficient protection.

### **3.5. Additional work and burden complying with the guidance**

Some respondents held more negative views on the impact of the guidance. Those that shared this stance believed the guidance could overburden pharmacy owners and pharmacy professionals as they attempt to comply with all aspects of the guidance. Some respondents spoke specifically about the

potential costs to pharmacy owners if they had to adapt the pharmacy to meet equality requirements, for example, making reasonable adjustments to the premises so that it is accessible. A few respondents also suggested that meeting all aspects of the guidance could increase the workload and stress levels amongst pharmacy staff.

### **3.6. Better protection and support for pharmacy staff**

A small number of respondents thought that the guidance would offer better protection for pharmacy staff, particularly those who share any of the protected characteristics. These respondents felt that the guidance would help promote a culture change within the pharmacy if employees and owners met their equality duties. A few respondents spoke specifically about discrimination in the pharmacy and how the guidance could help to address this.

### **3.7. The guidance is subjective and divisive**

A few respondents felt that it was difficult to assess the true impact of the guidance, saying that the broad themes covered in the guidance were too subjective. For this reason, achieving consistency on how it will be applied in practice was difficult. It was also suggested that people share different and contrasting views on such issues, which may prevent the guidance from being implemented as intended.

### **3.8. The guidance will benefit owners**

A small number of respondents highlighted how the guidance would benefit pharmacy owners. These respondents believed that introducing the guidance would make sure that owners fully understand their responsibilities in meeting their equality duties. The suggestion was that an inclusive pharmacy would lead to benefits for the owner, as patients may be more willing to use their services. Although it was acknowledged that the benefits for the owner may be felt more in the long-term, a few respondents thought that the use of the examples may accelerate how quickly the owners will be able to understand what is required of them.

### **3.9. Time is required to assess the impact of the guidance**

Given the broad themes covered in the guidance, a few respondents thought that it would take time to assess and review its impact. A small number of respondents suggested that the guidance should be reviewed regularly to ensure that it remains consistent with other resources that the GPhC produces, and also that it remains up to date from a legislative perspective.

# Appendix 1: Summary of our proposals

Our commitment to produce equality guidance for pharmacies resulted from our EDI strategy. It is an entirely new piece of guidance, which is designed to support pharmacy owners in understanding and meeting the **standards for registered pharmacies**. However, it has relevance for the wider pharmacy team, including pharmacy staff and managers. The guidance does not list the legal duties under the **Equality Act 2010** and the **Human Rights Act 1998**. This is because all pharmacy owners must meet their legal responsibilities as well as meeting our standards.

The pharmacy owner is responsible for following the guidance, but we believe that the whole pharmacy team should read the guidance and be familiar with it. We also believe that this guidance will be useful for all employers of pharmacy professionals, whether they are regulated by the GPhC or not. Education and training providers will also find it useful, since students and trainees will then be aware of their responsibilities, right from the start of their pharmacy career.

The equality guidance is organised along the lines of the five principles in the standards for registered pharmacies:

- **Principle 1:** The governance arrangements safeguard the health, safety and wellbeing of patients and the public.
- **Principle 2:** Staff are empowered and competent to safeguard the health, safety and wellbeing of patients and the public.
- **Principle 3:** The environment and condition of the premises from which pharmacy services are provided, and any associated premises, safeguard the health, safety and wellbeing of patients and the public.
- **Principle 4:** The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public.
- **Principle 5:** The equipment and facilities used in the provision of pharmacy services safeguard the health, safety and wellbeing of patients and the public.

It covers a variety of topics underneath each of the principles and introduces some of the principles of the Equality Act that pharmacy owners must take account of, including:

- **the nine protected characteristics** (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation)
- **the 'duty to make reasonable adjustments'** to the property from which services are provided, to meet the needs of people with disabilities (including patients, service users and employees)
- **the duty to remove discrimination, harassment and victimisation**

We are the regulator of registered pharmacies, and the guidance reminds pharmacy owners of what we expect of them. This includes:

- the need to regularly assess the equality implications of their practices, policies and procedures
- the need to create an open and inclusive culture to allow staff to feel empowered and able to meet their own professional and legal obligations



- the need to encourage equality of opportunity and respect for diversity
- the need to develop a fair and inclusive approach in their service provision and their relationships with other healthcare professionals and service providers
- the need to create a safe and suitable environment, which accounts for and meets the diverse needs of their local communities

Our equality guidance also includes several examples, taken from the [\*\*GPhC Knowledge Hub\*\*](#) and our inspections, which allow pharmacy owners and pharmacy staff to learn from others and continuously improve the services they provide to patients and the public.

# Appendix 2: About the consultation

## Overview

The consultation was open for 8 weeks, beginning on 7 April and ending on 6 June 2022. To make sure we heard from as many individuals and organisations as possible:

- an online survey was available for individuals and organisations to complete during the consultation period. We also accepted postal and email responses
- we hosted a webinar aimed at pharmacy professionals, organisations, and other interested parties to explain the guidance and provide more information about the consultation
- we created a toolkit of materials for organisations to disseminate information about the consultation to their members, including a press release and a presentation
- we promoted the consultation through a press release to the pharmacy trade media, via our social media and through our e-bulletin Regulate.
- we carried out an online survey with our online public panel members. The survey was open from 27 April to 6 June 2022.

## Survey

We received a total of **190** written responses to our consultation. **172** of these respondents identified themselves as individuals and **18** responded on behalf of an organisation.

The vast majority of these respondents completed the online version of the survey, with the remaining respondents submitting their response by email, using the structure of the consultation questionnaire.

### Online public panel survey

Alongside the consultation survey we conducted a survey of our online public panel members. There were five questions exploring the public's experience of accessing pharmacy and other healthcare services with particular focus on where individual needs have been met and where they have experienced barriers to accessing services.

We received **63** responses to the survey and the findings of this survey have been written up in a separate report.

## Social media

We monitored social media activity during the consultation period and collated the feedback for inclusion in our consultation analysis.

# Appendix 3: Our approach to analysis and reporting

## Overview

Every response received during the consultation period has been considered in the development of our analysis. Our thematic approach allows us to fairly represent the wide range of views put forward, whether they have been presented by individuals or organisations, or whether we have received them in writing.

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

The purpose of the analysis was to identify common themes amongst those involved in the consultation activities rather than to analyse the differences between specific groups or sub-groups of respondents.

The term 'respondents' used throughout the analysis refers to those who completed the consultation survey. It includes both individuals and organisations.

Full details of the profile of respondents to the online survey is given in [Appendix 4](#).

For transparency, [Appendix 5](#) provides a list of the organisations that have engaged in the consultation through the online survey and email responses. One organisation asked for their participation to be kept confidential and their names have been withheld.

The consultation questions are provided in [Appendix 6](#).

## Quantitative analysis

The survey contained several quantitative questions such as yes/no questions and rating scales. All responses have been collated and analysed including those submitted by email or post using the consultation document.

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

A small number (less than five) of multiple responses were received from the same individuals. These were identified by matches on email address and name. In these cases, the individual respondent's most recent response was included in the quantitative analysis, and all qualitative responses were analysed.

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

Percentages are shown without decimal places and have been rounded to the nearest whole number. As a result, some totals do not add up to 100%. Figures of less than 1% are represented as <1%.

All questions were mandatory, and respondents had the option of selecting 'don't know'. Routing was used where appropriate to enable respondents to skip questions that weren't relevant. Skipped responses are not included in the tables for those questions.

## Qualitative analysis

This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations, email, and postal responses.

The qualitative nature of the responses here meant that we were presented with a variety of views, and rationales for those views. Responses were carefully considered throughout the analysis process.

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

Prevalence of views was identified through detailed coding of written responses and analysis of feedback from stakeholder events using the themes from the coding framework. The frequency with which views were expressed by respondents is indicated in this report with themes within each section presented in order of prevalence. The use of terms also indicates the frequency of views, for example 'many'/'a large number' represent the views with the most support amongst respondents. 'Some'/'several' indicate views shared by a smaller number of respondents and 'few'/'a small number' indicate issues raised by only a limited number of respondents. Terms such as 'the majority'/'most' are used if more than half of respondents held the same views. NB. This list of terms is not exhaustive and other similar terms are used in the narrative.

## The consultation survey structure

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

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

## Appendix 4: Respondent profile: who we heard from

A series of introductory questions sought information on individuals' general location, and in what capacity they were responding to the survey. For pharmacy professionals, further questions were asked to identify whether they were pharmacists, pharmacy technicians or pharmacy owners, and in what setting they usually worked. For organisational respondents, there were questions about the type of organisation that they worked for. The tables below present the breakdown of their responses.

### Category of respondents

**Table 4:** Responding as an individual or on behalf of an organisation (Base: all respondents)

Are you responding:	Total N	Total %
As an individual	172	91%
On behalf of an organisation	18	9%
<b>Total N and % of responses</b>	<b>190</b>	<b>100%</b>

### Profile of individual respondents

**Table 5:** Countries (Base: all individuals)

Where do you live?	Total N	Total %
England	141	82%
Scotland	16	9%
Wales	11	6%
Other	4	2%
<b>Total N and % of responses</b>	<b>172</b>	<b>100%</b>

**Table 6:** Respondent type (Base: all individuals)

Are you responding as:	Total N	Total %
A pharmacist	126	73%
A pharmacy technician	34	20%
A member of the public	5	3%
Other	7	4%
<b>Total N and % of responses</b>	<b>172</b>	<b>100%</b>

**Table 7:** Main area of work (Base: individuals excluding members of the public)

Sector	Total N	Total %
Community pharmacy	90	54%
Hospital pharmacy	25	15%
Prison pharmacy	1	1%
Primary care organisation	7	4%
GP practice	10	6%
Care home	1	1%
Pharmaceutical industry	7	4%
Research, education or training	8	5%
Other	18	11%
<b>Total N and % of responses</b>	<b>167</b>	<b>100%</b>

**Table 8:** Size of community pharmacy (Base: individuals working in community pharmacy)

Size of pharmacy chain	Total N	Total %
Independent pharmacy (1 pharmacy)	23	26%
Independent pharmacy chain (2-5 pharmacies)	13	14%
Small multiple pharmacy chain (6-25 pharmacies)	10	11%
Medium multiple pharmacy chain (26-100 pharmacies)	7	8%
Large multiple pharmacy chain (Over 100 pharmacies)	36	40%
Online-only pharmacy	1	10%
<b>Total N and % of responses</b>	<b>90</b>	<b>100%</b>

## Profile of organisational respondents

**Table 9:** Type of organisation (Base: all organisations)

Please choose the option below which best describes your organisation	Total N	Total %
Organisation representing patients or the public	2	11%
Organisation representing pharmacy professionals or the pharmacy sector	6	33%
Registered pharmacy	3	17%
NHS organisation or group	3	17%
Regulatory body	1	6%

Please choose the option below which best describes your organisation	Total N	Total %
Other	3	17%
<b>Total N and % of responses</b>	<b>18</b>	<b>100%</b>

**Table 10:** Type of community pharmacy (Base: organisations working in community pharmacy)

Which of the following best describes the community pharmacy you work in (or own)	Total N	Total %
Large multiple community pharmacy chain (over 100 pharmacies)	2	67%
Online-only pharmacy	1	33%
<b>Total N and % of responses</b>	<b>3</b>	<b>100%</b>

## Monitoring questions

Data was also collected on respondents' protected characteristics, as defined within the Equality Act 2010. The GPhC's equalities monitoring form was used to collect this information, using categories that are aligned with the census, or other good practice (for example on the monitoring of sexual orientation). The monitoring questions were not linked to the consultation questions and were asked to help understand the profile of respondents to the consultation, to provide assurance that a broad cross-section of the population had been included in the consultation exercise. A separate equality impact assessment has been carried out and will be published alongside this analysis report.

# Appendix 5: Organisations

The following organisations responded to the consultation:

Boots

Company Chemists' Association

Community Pharmacy Scotland

Community Pharmacy Wales

Directors of Pharmacy, NHS Scotland

Diversity and Ability

Healthcare Improvement Scotland

Healthwatch Milton Keynes

L Rowland & Co (Retail) Ltd

Medical Information for Ethnic Minorities

National Pharmacy Association

NHS Education for Scotland

Pharmacists' Defence Association

Professional Standards Authority

Royal Pharmaceutical Society

Turning Point

Written Medicine



## Appendix 6: Consultation questions

1. Thinking about the structure and language of the guidance, do you think it is easy to understand?
2. Thinking about the structure and language of the guidance, do you think it is easy to apply?
3. Please give comments explaining your answers to the two questions above.
4. Thinking about the areas covered in the guidance, do you think we have missed out anything important?
5. If 'Yes', please describe the areas we have missed.
6. Do you think our proposals will have a positive or negative impact on: each of the following groups?
  - Patients and the public
  - Pharmacy staff
  - Pharmacy owners
7. Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the following protected characteristics (as listed in the Equality Act 2010)?
  - age
  - disability
  - gender reassignment
  - marriage and civil partnership
  - pregnancy and maternity
  - race
  - religion or belief
  - sex
  - sexual orientation
8. Please give comments explaining your answers to the two impact questions above. Please describe the individuals or groups concerned and the impact you think our guidance would have.

# Appendix 7: The impact of the proposed changes on people sharing particular protected characteristics

## Individual responses

**Figure 3:** Views of individual respondents (N = 172) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010

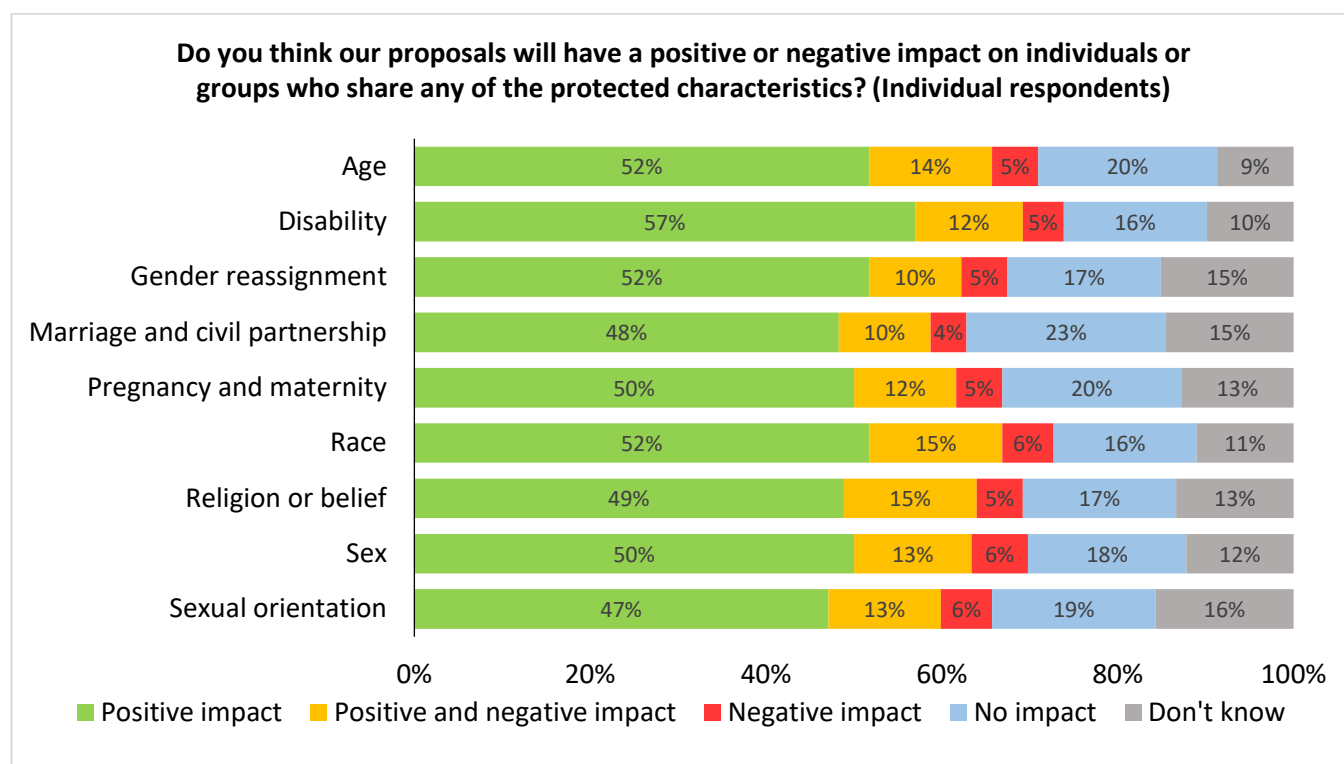


Figure 3 shows that most individual respondents (between 47% and 57%) thought that the proposals would have a positive impact on all individuals or groups who share any of the protected characteristics. Disability (57%) was the protected characteristic that respondents thought would have the largest positive impact, compared to sexual orientation (47%) which saw the least.

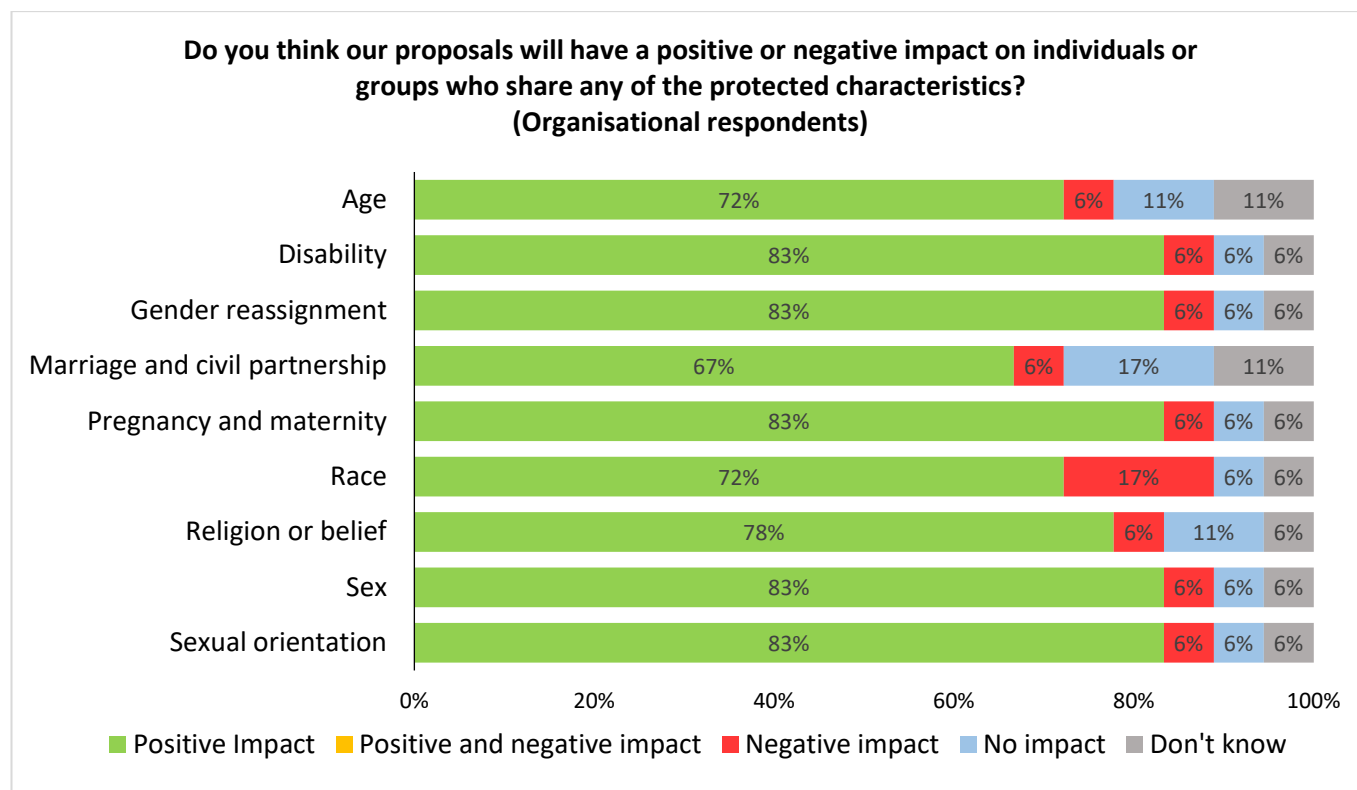
Between 16% and 23% indicated that the proposals would have no impact on the groups listed above. Only a very small percentage of individual respondents (4%-7%) thought that the guidance would have a negative impact.

A similar proportion of individual respondents (between 9% and 16%) thought that the guidance would have both a positive and negative impact, or stated that they did not know.

NB. Please see section 3 in the main body of the report for the chart showing the overall responses and further analysis.

## Organisational responses

**Figure 4:** Views of organisations (N = 18) on whether our proposals positively or negatively impact any individuals or groups sharing any of the protected characteristics in the Equality Act 2010



The majority of organisational respondents (between 67% and 83%) thought that the guidance would have a positive impact on individuals or groups who share any of the protected characteristics. Marriage and civil partnership (67%) was viewed as the characteristic that would have the least positive impact.

A relatively small number of respondents thought that the proposals would have no impact on the groups identified above, with the exception of marriage and civil partnership where 17% felt that there would be no impact.

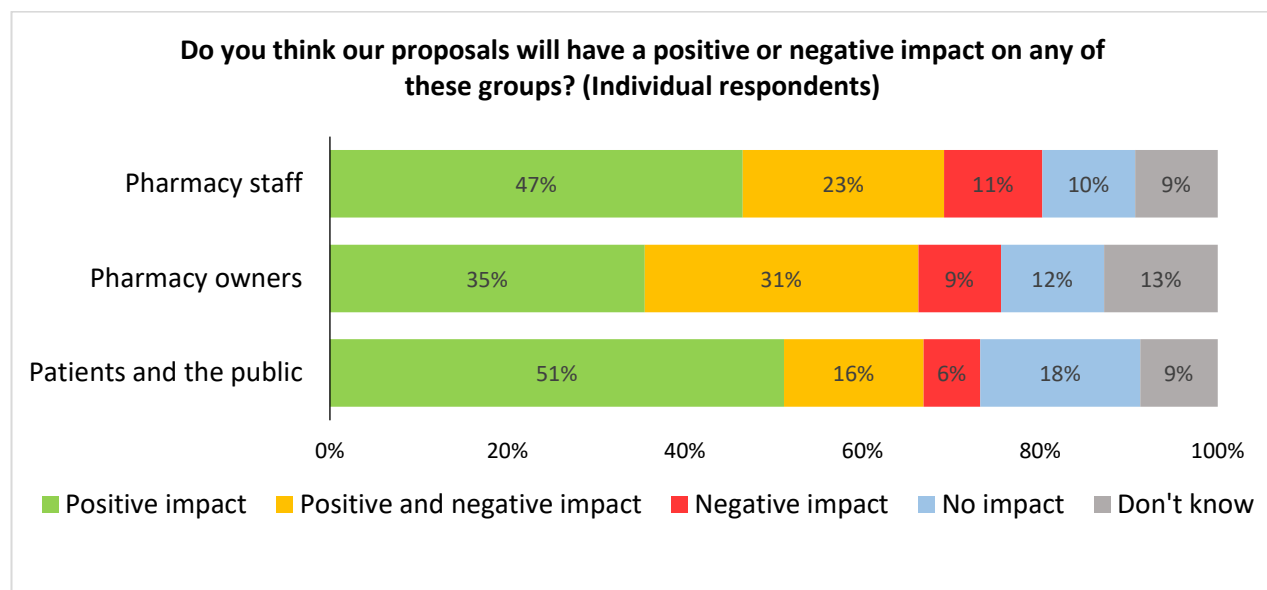
Organisational respondents thought that there would be small negative impact on the groups identified above (6% each), with the exception of race where 17% thought that there would be an overall negative impact.

NB. Please see section 3 in the main body of the report for the chart showing the overall responses and further analysis.

# Appendix 8: The impact of the proposed changes on other groups

## Individual responses

**Figure 5:** Views of individual respondents (N = 172) on whether our proposals positively or negatively impact other individuals or groups



Pharmacy staff (47%) and patients and the public (51%) were frequently identified by individual respondents as groups that would be positively impacted by the proposals. However, individuals were slightly less optimistic about the impact on pharmacy owners with around a third indicating that this group would be positively impacted.

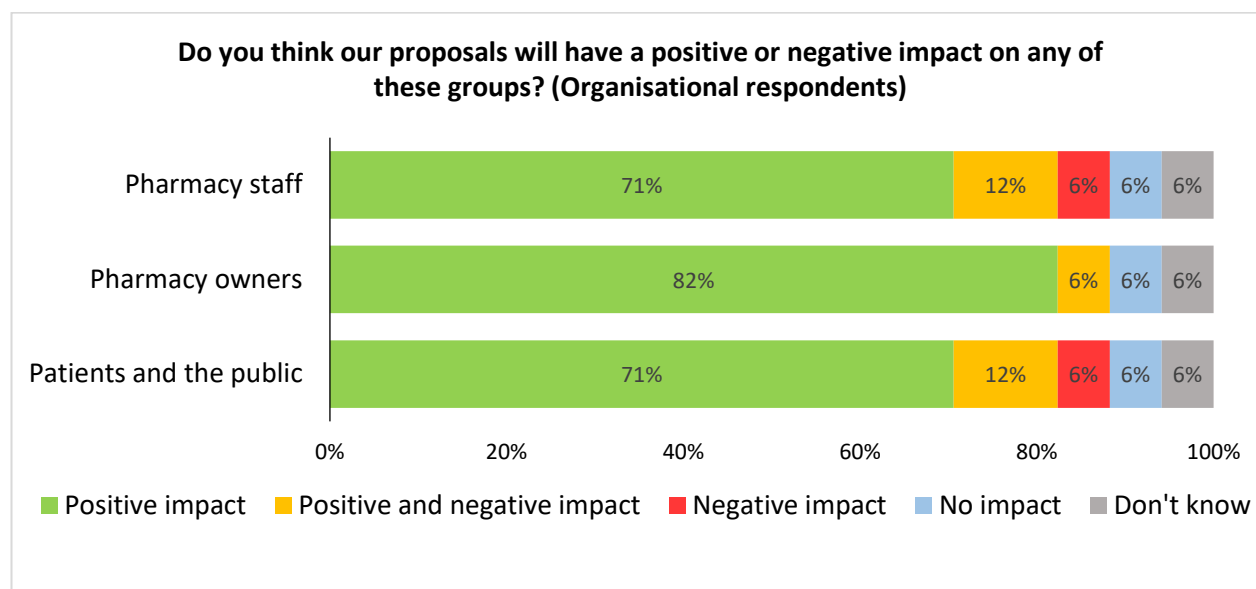
A higher proportion of individuals thought that pharmacy owners (31%) would see both a positive and negative impact compared to pharmacy staff (23%) and patients and the public (16%).

Individual respondents indicated that pharmacy staff (11%) would be the group most negatively impacted by the guidance, whilst patients and the public were identified as the group that would most likely not see any impact (18%).

NB. Please see section 3 in the main body of the report for the chart showing the overall responses and further analysis.

## Organisational responses

**Figure 6:** Views of organisations (N = 18) on whether our proposals positively or negatively impact other individuals or groups



A large majority of organisations (between 71% and 82%) thought that the proposals would have a positive impact on the groups identified above, with pharmacy owners coming out on top (82%). A very small number of organisations thought that there would be a negative impact resulting from the guidance (6%), and the organisations felt that there would be no negative impact at all on pharmacy owners.

Around 6% of organisations thought that the proposals would have no impact or stated that they did not know what type of impact the proposals would have on all the groups identified above.

NB. Please see section 3 in the main body of the report for the chart showing the overall responses and further analysis.

## Equality guidance survey with GPhC public panel: analysis report

# Contents

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# Introduction

Between April and June 2022, we consulted on our new equality guidance for pharmacies. Details of the consultation together with the analysis report on the findings can be found here [link to be added].

Alongside the consultation on equality guidance for pharmacies, we carried out a survey with members of our public panel between 27 April and 6 June 2022. We received 63 responses. This report is an analysis of the findings.

Through the survey we asked about people's positive experiences of using pharmacy, any barriers they faced and any improvements they could suggest. We also asked about their positive experiences and barriers when accessing other healthcare services. Participants were asked to consider their own experience and that of family members. See [Appendix 1](#) for the survey questions.

The survey was designed to give us a bigger picture of people's lived experiences when accessing pharmacy and healthcare. This is an important aspect of our EDI strategy, which sets out our commitment to improve the way we reflect and integrate lived experience and patient voice in all of our work.

Participants were also asked if they would be willing to be quoted or for their experiences to be developed into a short case study. 54 participants agreed to this. We have used direct quotes from responses in this report. We plan to use quotes from responses and develop case studies to further bring to life the equality guidance for pharmacies in the future.

## Summary of findings

### Positive experiences of pharmacy and other healthcare services

Overall the majority of comments showed that people had not experienced any barriers to accessing safe and effective care from pharmacies or wider healthcare services.

Most people reported that they had experienced efficient services, such as repeat prescriptions always being ready and medicines continuing to be supplied during COVID-19 pandemic lockdowns.

Receiving person-centred care was also reported by the majority of participants. This included people commenting on professionals' positive attitudes to patients and meeting their individual needs.

Participants commented positively about the expert knowledge or advice they had been given including positive experiences of medication reviews, pharmacists being able to change prescriptions when required and general health advice and reassurance.

### Negative experiences of pharmacy and other healthcare services

Some participants reported they had experienced poor or limited access to healthcare services, such as long waiting times, not being able to get a face-to-face appointment and difficulty getting through to services by phone. There were a number of comments that noted the challenges of accessing services during the COVID-19 pandemic.

Some participants felt they had not received person-centred care. This included professionals having a negative attitude towards patients, individual needs not being addressed and invisible disabilities not being understood.



Medicines shortages and delays were reported by some participants. This included people having to make multiple trips to the pharmacy as prescriptions could only be part filled and multi-compliance aids being unavailable.

## Analysis of survey responses

### Experiences of pharmacy

#### Positive experience of pharmacies providing safe and effective care

The top three themes reported in order of prevalence on positive experience were efficient services, person-centred care, and expert knowledge.

##### Experiencing efficient services

There were a number of positive experiences reported that related to receiving services efficiently. Many participants commented that their repeat prescriptions were always ready when they needed them and were appreciative that they could still access the medicines they needed during the COVID-19 pandemic. Participants were positive about experiences with urgent referrals and flexibility around appointments for vaccinations and other services. Respondents were also very pleased about being able to access pharmacy professionals on the high-street and without the need for an appointment. Comments included:

“My partner (as a transgender woman) does have some specific needs for medication and our pharmacy has been really good at ensuring provision of these”

“My local pharmacy rang me to let me know that my emergency prescription for available for collection which then enabled me to only take minimum amount of time off work as was necessary to collect my prescription.”

“My mother is disabled and housebound and her local pharmacy liaise with her and her GP practice to deliver her prescriptions to her home. This works very well for her.”

##### Receiving person-centred care

Participants described experiencing person-centred care when their individual needs were taken into account and met, and when the pharmacy teams demonstrated a positive attitude towards them. Many participants reported that they felt their pharmacy teams had gone above and beyond to help them by making sure medicines were supplied in the most suitable format for the patient or arranging collection and deliveries that fitted around individual's personal circumstances. Respondents also noted the efforts of pharmacy teams in ensuring information is explained in a way the person understands. There were many positive reports of people feeling listened to and respected when using pharmacies. Additionally, a number of participants commented on the positive relationship they have with the pharmacy team who remember who they are and their needs and preferences. Comments included:

“My dad isn't very confident speaking English however the local pharmacist (who is also Indian) will make time and appointments for my dad to go in and speak to him about his medication.”

“The pharmacy have been particularly helpful in providing my son's medication. He is autistic and can struggle with change - so when tablets change colour or the box is different can be very difficult to manage. They were really understanding and explained they had little control over the boxes but each time they check to see what colour the tablets are so we also get white ones.

They even remember who I am and ask how he is doing. This is a busy and big instore pharmacy so it's pretty impressive that they personalise the service so much. They never make me feel like I am a nuisance."

"Back when I was requiring a fairly intensive treatment regime for a chronic condition I live with, my local pharmacy were very helpful in finding me an alternative form of medication for one particular medicine as I can't swallow tablets. They were able to get my prescription changed to a granular form of the medicine which made it much easier for me to take it and had more of the impact that was needed since I was able to better absorb the medication."

### **Expert knowledge of pharmacy professionals**

Participants were positive about the expert knowledge pharmacy teams demonstrated. There were a number of positive experiences shared in responses related to health advice given, to helping people find treatment options that worked for them and in doing medicines reviews. Participants found it especially helpful when a pharmacist could change a prescription if required, or checked back with a GP if they had a concern about the prescription. Comments included:

"As a Warfarin user, when taking additional medications, I often ask to speak to a pharmacist to discuss possible interactions and/or contraindications between medicines. Almost without exception their advice is patient, respectful, well-informed and reassuring."

"My partner had a rash on his face and while we were out asked the pharmacist to look at it, he was told to contact his GP immediately and it turned out it was Shingles."

### **Barriers to accessing safe and effective care when using pharmacies**

The vast majority of participants reported that they had not experienced any barriers to accessing safe and effective care when using pharmacies. A few participants shared experiences where they had received a poor service or where their individual needs had not been met. Some reported issues with short supplies of medicines and problems with deliveries. Some reported problems with accessing pharmacies due to opening hours or waiting times.

#### **Individual needs not being met**

A few participants shared experiences where their individual needs were not met or where they had experienced a poor service. While such comments were rare in the survey responses, they show the significant impact these individuals experienced:

"When I used a busy central pharmacy, limited by my own working hours, the waiting times to get to the counter caused an issue for me as I have an 'invisible' disability (a connective tissue disorder) which means I cannot stand for long periods of time. Whilst allowances were made for the elderly or noticeably infirm, I was unable to avail of this help without drawing attention to myself, which can be embarrassing, and I don't always have the energy for."

"Pharmacist would not assist husband when he was having an asthma attack in a chemist shop. The pharmacist was quite abrupt and really unhelpful. We cannot be sure that there weren't racist motivations behind lack of help as my husband is Asian. Husband was eventually helped by a member of the public."

### Short supplies of medicines and problems with deliveries

A few participants reported experiences of medications not being available or some but not of all a prescription medicine being available. Hormone replacement therapy was mentioned specifically by a couple of participants as being particularly hard to access. Comments included:

“I have very often been let down by my pharmacy, not having my medications on time or delivering only part of my medication”.

“It is a constant stress at the moment that I may not be able to obtain my HRT medication. Without which, among other symptoms, I experience severe cognitive issues which mean I cannot drive, work or self-advocate - or chase around trying to find where supplies are available. However, I recognise that supply issues are outside of the individual pharmacies’ control.”

“I have 28 prescribed medicines. When my GP practice stopped using the CMS (chronic medication service) I now have to constantly keep on top of ensuring I have enough medication. Often I am unwell and cannot travel to the pharmacy. I have asked my pharmacy if they would deliver to me but they refused saying priority goes to those in greater need. However, I feel I am as much need of pharmacy deliveries as many of the customers who get their prescriptions - many of them have cars, I have to travel on public transport to my pharmacy.”

### Issues with accessing pharmacies

A few participants commented that opening times were a barrier or that they had received a poor service. Comments included:

“Only barrier is opening times. Many local Pharmacies close for lunch and this can be difficult for me as my mother’s medicines often need changes made, and I live a distance away, so have to wait till they reopen.”

“My daughter’s epilepsy medication order was cancelled by accident by the pharmacy and she ended up running out with another 3 days until they could get it in again. They couldn’t help to come up with alternatives and just told me to contact the GP.”

### Improvements pharmacies could make to better meet individual needs

The majority of participants reported that they were satisfied with their pharmacy and did not think any improvements were needed.

Some suggestions were made including closer working relationships between the pharmacy team and GPs, longer opening hours, more confidential spaces for private conversations, and raising awareness of invisible disabilities.

“More liaising directly with doctors, more abilities to allow for changing medication especially in the case of the patient having side effects”

“Be aware of invisible disabilities. Adopt a kind, patient and empathic approach to customers (our own pharmacy is seriously lacking in this area). Be aware that some people may need to be spoken to away from other customers.”

“I feel in our local pharmacy there could be better staffing and an easier way for a confidential conversation if required. There is a room they use for injections but generally customers are trying to converse through a plastic screen with a queue of people behind over hearing the conversation.”

## Experiences of other healthcare services

### Positive experience of other healthcare services providing safe and effective care

When asked about their experience of using wider healthcare services, the majority of participants reported they had received person-centred care, said they experienced efficient services and commented on expert knowledge and advice given. A minority reported that their needs had not been met.

#### Receiving person-centred care in other healthcare services

Comments included:

“When my autistic son broke his ankle he was seen quickly at the minor injuries unit to ease his anxiety. When we went to the trauma department appointment he couldn't get out of the car as he was so distressed - they were really great and came out to talk to him about what would happen when he came in. They said he could come in any time and not to worry about the appointment time. They saw him quickly once we got in and did things as they said they would. They were very accommodating and understanding and changed the process so he was as comfortable as possible because of the sensory impact of his broken ankle.”

“I have a phobia of needles. When I have needed to have an injection at the dentist I always ask them to make sure I don't see the needle. They have done this.”

#### Experiences of efficient services in other healthcare services

Comments included:

“When I call my mother's GP re her many illnesses they are always prompt in arranging appointments or follow up calls. This is important for elderly people as their condition can change quickly, and is therefore greatly appreciated.”

“My parents both suffer with mobility issues. Their GP will make home visits often popping into work before or after his shift which was such a comfort during the pandemic.”

#### Experiences of expert advice and knowledge in other healthcare services

Comments included:

“Hospital and GP staff listen and clarify needs when presenting. On a recent ambulance call out by the 111 triage service, responding to shoulder and chest pain, was reassured by the tests and examination of the ambulance crew that it was not a heart attack but muscular.”

“I was able to send a photograph of my 4 month old grandson's rash on his back (possibly due to COVID) to my GP for further information about whether he needed to be seen in person. The result was that the consultation was quick and alleviated the worries that my daughter-in-law and son had about their little boy.”

### Barriers to accessing safe and effective care when using other healthcare services

Some participants reported issues with accessing other healthcare services due to long waiting times and a lack of appointments being available. A similar proportion of participants said that they had not experienced any barriers to accessing safe and effective care when using other health services. A few shared experiences of their individual needs not being met, with a number of these participants referring to long-term conditions or disabilities as part of their response.

## Issues with accessing other healthcare services

Comments included:

“Currently my parents have issues using online booking for the GP and are very frustrated that everything is still being done on the phone and not face to face.”

“We have to wait a long time to see a GP, getting through to NHS 24 on 111 is a nightmare, I’ve waited over 50 minutes on the phone getting through and it’s annoying hearing about the website etc, also we have waited over 5 hours for an ambulance arriving to take my wife to hospital and that was six hours earlier than we had been told the wait would be!!!”

“The greatest barrier has been the wait time to be seen by a professional when referred. It took about 4 months to have a first appointment with a neurologist.”

## Individual needs not being met

Comments included:

“It has proved impossible to get my son the mental health support that he needs. The local autism service want this to be provided via the adult mental health services. The first level mental health team can only offer group work which he is unable to take part in and willingly admit that they are not experienced in autism. The next tier do not see him as being severe enough to access them. Consequently he falls between all the services, remains on sertraline for anxiety (for over 6 years) with no input to help him to develop coping strategies.”

“Sadly, many HCPs do not recognise or understand the nature of ‘invisible’ disabilities. Also, having a structural disability which affects my whole body adds complexity to our healthcare model which tends to focus on individual specialisms rather than a ‘whole body’ approach.”

“Elderly mother with Alzheimer’s in a different part of the country sent from care home to A and E. No chaperone to represent her in her confused state.”

## Comparison of pharmacy and other healthcare services

### Comparing positive experience of pharmacy and other healthcare services

Participants generally reported a more positive experience of pharmacy meeting their needs in comparison with other healthcare services.

A greater number of participants reported they experienced efficient services in pharmacy compared to efficient services for other healthcare services.

More participants felt they received person-centred care in pharmacy compared to other healthcare services.

Additionally, more participants commented on expert knowledge and advice in pharmacy, than in relation to other healthcare services.

### Comparing experience of barriers to safe and effective care in pharmacy and other healthcare services

Participants were significantly more likely to experience no barriers to accessing pharmacy than other healthcare services.

A significant number of participants reported poor or limited access to other healthcare services, while fewer mentioned this in relation to pharmacy.

Reporting experiencing a lack of person-centred care was similar between pharmacy and other healthcare services, raised by a small proportion of respondents.

## **Protected characteristics and long-term conditions**

As illustrated in some of the examples above, respondents often referred to protected characteristics or long-term conditions in their responses. There were positive reports of people experiencing care that met their individual needs, such as offering advice in languages other than English, providing appointments that took into account people's caring responsibilities and providing medicines in a form that best met an individual's needs. However, there were also comments about negative experiences, particularly in relation to a lack of understanding of invisible disabilities and challenges around long waiting lists and difficulties in accessing services.

# Appendix 1: Survey questions

1. Can you share any examples of where a pharmacy has met your (or a family member's) individual needs and preferences?
2. Can you share any examples of where your (or a family member's) individual needs and preferences have been met when accessing other healthcare services, such as a GP or hospital?
3. Have you (or a family member) experienced any barriers to accessing safe and effective care when using pharmacies?
4. Have you (or a family member) experienced any barriers to accessing safe and effective care when using other healthcare services?
5. What more could pharmacies do to help improve your experience and meet your (or a family member's) individual needs?

# Equality guidance for pharmacies

## About this guidance

### Our role

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacies in England, Scotland and Wales. As part of our role, we set the standards that pharmacy professionals have to meet throughout their careers, as well as the standards that pharmacy owners are responsible for meeting, to ensure the safe and effective provision of pharmacy services at or from a registered pharmacy.

### Our commitment

In our **Vision 2030** and our **strategic plan 2020-25**, we have committed to an ‘anticipatory and proportionate’ approach to regulation. This means that we will be using data, intelligence and insights that we have, and those we receive from others, to help us get ahead of issues before they happen or become bigger issues.

We have also committed to delivering equality, improving diversity and fostering inclusion in everything we do as a regulator and employer. This commitment to equality, diversity and inclusion (EDI) is explained in our **strategy for change 2021-2026**.

We created our EDI objectives based on information we gathered in a number of ways. These included through our growing understanding of the public we serve and the pharmacy professions we regulate. We gathered information through:

- the pharmacy practice examples collected by our inspections team, which are on the **GPhC knowledge hub**
- the feedback and concerns we received from members of the public and others, telling us about their experiences of pharmacy
- the comments, reactions and feedback we received in response to our **EDI strategy consultation**
- our earlier **research into registration assessment performance**

As the pharmacy regulator, we have a legal responsibility to promote equality and fight injustice in all aspects of our work, including in pharmacies. The law says we must have ‘due regard’ to the need to eliminate unlawful discrimination, harassment and victimisation, and to advance equality of opportunity between people from different groups. We must also foster good relations between people from different groups when carrying out all our day-to-day functions and activities as a public body.



## The purpose of this guidance

This guidance is designed to help support pharmacy owners in understanding and meeting the **standards for registered pharmacies**. However, it has relevance for the wider pharmacy team, including pharmacy staff and managers. You should read it alongside the standards for registered pharmacies, which aim to create and maintain the right environment – both organisational and physical – for the safe and effective practice of pharmacy.

We have included several examples taken from the GPhC Knowledge Hub and our inspections. These show ways in which registered pharmacies are meeting their equality duties. We have also conducted an online public panel member survey which is helpful to understand the impact service delivery has on people. The findings from the survey can be found in Annex 2. Pharmacy owners and pharmacy staff should use the examples included in the guidance as well as the findings from the public panel member survey to learn from others and think about how they can continuously improve outcomes for the people using their pharmacy's services.

The guidance does not list the legal duties under the **Equality Act 2010** and the **Human Rights Act 1998**. This is because all pharmacy owners must meet their legal responsibilities as well as meeting our standards. For more information, please see the section 'Other useful sources of information' at the end of this document.

By following this guidance, pharmacy owners will:

- demonstrate that they are meeting our standards
- help protect the rights of individuals
- advance equal opportunity for staff, patients, and the wider public, and
- help improve the experience and healthcare outcomes of patients and members of the public using their pharmacy's services

In this document when we use the term 'staff' this includes:

- employees (registrants and non-registrants)
- agency and contract workers (including pharmacy locums), and
- any third party who helps the pharmacy provide any part of the pharmacy service, and deals on behalf of the pharmacy owner with people who use pharmacy services

## Who this guidance is for

The pharmacy owner is responsible for making sure this guidance is followed. In this document, the term 'you' means the pharmacy owner.

If the registered pharmacy is owned by a 'body corporate', the directors have responsibility. People responsible for the overall safe running of the pharmacy need to consider the size and nature of the pharmacy, the range of services provided and, most importantly, the needs of patients and members of the public.

However, everyone in the pharmacy team should read this guidance and be familiar with it, including staff and managers with delegated responsibility. We also believe this guidance will be helpful for other organisations who employ pharmacy professionals or provide pharmacy services, and across a range of settings – whether or not we regulate those settings.

We expect you to follow this guidance. Not following the guidance might mean that you fail to meet one or more of the standards for registered pharmacies. This could result in our taking enforcement action – you can see more information about this in the GPhC's **Registered pharmacies enforcement policy**.

However, we recognise that the nature and scale of a pharmacy business has a significant impact on the resources and systems it can use to meet our standards and guidance. We also recognise that there can be different ways to meet our standards and achieve the same outcomes for patients – that is, to provide safe and effective treatment, care and services.

If you do not follow this guidance, you should be able to show how your alternative ways of working safeguard patients, identify and manage any risks, and meet both our standards and any legal requirements.

# Introduction

## What is equality?

The Equality Act came into force in 2010, bringing together more than a hundred separate pieces of legislation into one single Act. It applies to everyone in Great Britain who provides goods, facilities or services to the public. This includes registered pharmacy premises.

Equality is about making sure that people, or groups of people, are not treated less favourably because of their protected characteristic(s). It is also about everyone having an equal opportunity to make the most of their potential. This may mean that, at times, people are not just treated 'the same', but in ways that reflect their individual needs and characteristics, and the inequality they may experience.

## The nine protected characteristics

The nine protected characteristics, as defined by the Equality Act 2010 are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

For more information, please see Annex 1.

## The role of pharmacy owners

Pharmacy owners are responsible for ensuring the safe and effective provision of pharmacy services from a registered pharmacy. They are accountable for making sure that the standards for registered pharmacies are met, and for creating and supporting an environment in which pharmacy professionals can demonstrate their professionalism and deliver person-centred care.

There is a growing urgency, both in society as a whole and within pharmacy, to tackle all forms of inequality. As a service provider, it is essential that you create an environment where you protect the safety and welfare of both your team and patients, and work within the law.

This includes making sure that no one is unlawfully discriminated against, either in your workplace or when you provide services.

## Why is this important?

As well as being a legal and regulatory duty, embedding the principles of equality and human rights in your pharmacy is the right thing to do.

A person-centred approach to care can improve the experience of people using your services, the care they receive, and the health outcomes of the whole community that you serve.

Your efforts to deal with health and workforce inequalities – and to remove the barriers that people face when trying to access health and care services – can also bring benefits to society and the wider economy. This can be measured in several ways, including:

- improved access to services, as some people may be more likely to go for care and support to pharmacies with whom they share some social or cultural characteristics
- lower levels of ill-health among the local population
- higher productivity from staff
- improved staff morale and engagement
- greater staff loyalty and retention
- lower levels of sickness absence and absenteeism

The four main types of discrimination are:

- direct discrimination (that is, treating one person worse than another person because of a protected characteristic)
- indirect discrimination (that is, when there is an organisation's policy that applies in the same way for everybody but disadvantages a group of people who share a protected characteristic)
- harassment (that is, treating people in a way that violates their dignity, or creates a hostile, degrading, humiliating or offensive environment), and
- victimisation (that is, treating people unfairly if they decide to take action under the Equality Act, or if they support someone else who is doing so)

For more information, please go to the Equality and Human Rights Commission (EHRC) website.

It can also help to reduce the chance of unnecessary disciplinary and fitness to practise actions being brought against your pharmacy if you encourage greater awareness and understanding of the different protected characteristics, and tackle discrimination and prejudice. Complaints, grievances and employment tribunal claims can be costly and disruptive for your pharmacy.

Pharmacy owners can lessen the risk of this sort of financial and reputational damage by meeting their equality and human rights responsibilities, and by following the standards for registered pharmacies.

## Your obligations

### Legal obligations

All providers of public services need to meet the Equality Act 2010 sections that relate to service provision and to employment.

As a service provider, you must keep to the law. The law sets out the minimum legal obligations that you must meet to remove the potential for discrimination, harassment and victimisation. Equality law affects everyone responsible for running your business or who might do something on its behalf, including your staff.

The Equality Act 2010 introduces the 'duty to make reasonable adjustments' to the property you provide services from, to meet the needs of disabled people (including your employees). This may mean:

- changing the way you deliver services
- providing extra equipment, and
- removing physical barriers

Importantly, you must not pass on the costs of making these adjustments to others.

The duty to make reasonable adjustments is 'anticipatory'. This means that you should think in advance (and from day to day) about what people with a range of impairments might reasonably need. These could include:

- changes to the physical features of your pharmacy (that is, its design, construction, entrance, exit, fixtures, fittings, furnishings and so on)
- adding an 'auxiliary aid' (such as an induction loop for people with hearing difficulties), and
- providing help with, or changes to, how information is provided

What is 'reasonable' will depend on the size and circumstances of your pharmacy. The adjustments you make do not necessarily need to be about costly installations or introducing permanent features. This might be unreasonable for the scale of your business, or impossible in the context of your premises. The reasonable adjustments you make should be adequate to the services you provide and the needs of the local population you serve.

As far as your staff are concerned, your duty to make reasonable adjustments for them is not anticipatory. This means that you only have to make adjustments if you are aware that a worker has a disability. For example, this may be someone who is applying for a job at your pharmacy and needs an adjustment to help them through the application process. Or an existing member of your team may develop a disability. You must then take steps to remove, reduce or prevent the obstacles that person might face in applying for, doing, or keeping their job.

## **Regulatory obligations**

Your regulatory obligations go beyond your legal ones.

We expect you to take whatever steps you need to run your pharmacy in a way that encourages equality of opportunity and respect for diversity.

You are responsible for creating and supporting an environment in which pharmacy professionals can:

- demonstrate their professionalism, and
- deliver person-centred care that takes account of the diverse needs and cultural differences in the communities you serve

We expect you to be fair and inclusive in your approach to everything you do, including your interactions with people you meet and deal with through the course of your work. This includes your relationships with patients, other healthcare professionals and service providers, and other people you work with.

As a pharmacy owner, you have an important role to play in carrying out your equality policies and procedures and in achieving fair outcomes. You must act with integrity and honesty, and in a way that is fair, inclusive, and transparent.

When possible, your approach to equality should include everyone, including people who may face disadvantage because of their socio-economic background, their caring responsibilities, language barriers or other challenges.

As a pharmacy owner, you also have a responsibility to encourage diversity at all levels of your workforce.

# Equality and the GPhC standards for registered pharmacies

This guidance is set out under each of the five principles used in our standards for registered pharmacies.

## **Principle 1: The governance arrangements safeguard the health, safety and wellbeing of patients and the public.**

### **1.1 Identifying and managing risk**

Pharmacy owners have an important responsibility to identify and manage the risks associated with providing pharmacy services.

A targeted risk assessment is a useful way to identify anything in the pharmacy that could prevent patients from accessing pharmacy services or prevent staff from providing services. You then need to decide what to do to keep this risk as low as reasonably practicable. An example of a risk is when a pharmacy professional's religion, personal values or beliefs might affect their willingness to provide certain services. For more information, please see our [\*\*guidance on religion, personal values and beliefs\*\*](#).

Risk assessments need to consider the circumstances of each individual pharmacy. They should be reviewed and updated regularly, and as required in response to significant changes; for example, in the range of services provided; in staffing; in the population being served, or in the physical premises.

The findings of risk assessments should ideally provide clear recommendations, whenever appropriate. These should say how reasonable adjustments are to be made, and the timescales for doing this.

The following example shows how pharmacy owners can meet the requirement to identify and manage risk. It may not apply in all situations and there may be other ways to meet this requirement.

#### ***Example: Identifying and managing risk***

##### **Context**

Acknowledging that people from ethnic minority backgrounds, as well as some other groups, are being disproportionately affected by COVID-19, a pharmacy owner took steps to risk assess staff and patients.

##### **What measures were taken?**

The pharmacy owner put appropriate arrangements in place to protect their staff, trainees, and their patients. Occupational risk assessments helped identify at-risk and vulnerable people within the team, including staff from ethnic minority backgrounds, along with other vulnerable groups, such as those with existing health conditions.

For patients that were exceptionally vulnerable, the owner arranged to deliver the patient's medication to their home, so that they didn't have to come into the pharmacy.

## 1.2 Reviewing and monitoring the arrangements in place

Pharmacy owners should regularly review and monitor the safety and quality of pharmacy services. You should also do this whenever circumstances change – for example, when significant business or operational changes are made.

Any changes to your governance arrangements, systems or policies could disproportionately disadvantage certain groups or individuals, and therefore need to be carefully monitored. Similarly, if the existing arrangements have been in place for a while, you should make sure they are still fit for purpose and do not adversely affect certain groups or individuals.

Before introducing any new practices, policies, or procedures, you may also want to consider whether to carry out an Equality Impact Assessment (EIA). An EIA is an analysis of a proposed organisational policy, or a change to an existing one. Its aim is to assess whether the policy has a disproportionate impact on people who share one or more of the protected characteristics. EIAs are often carried out by public bodies to help them meet their equality duties. But they can also be a useful tool for you to use in your pharmacy.

Carrying out an EIA is an example of good equality practice. However, it does not necessarily need to result in a written document or report. You should be able to demonstrate that you have taken equality considerations into account if you have:

- based your decisions on evidence
- thought about any unintended impacts and how to lessen these, and
- kept a record of your decisions

For further background information on EIAs, please see our ‘other useful sources of information’ section at the end of this document.

The following example shows how pharmacy owners can meet the requirement to review and monitor arrangements. It may not apply in all situations and there may be other ways to meet this requirement.

### ***Example: Reviewing and monitoring arrangements***

#### **Context**

A community pharmacy was considering a complete refit of the premises. As part of this, the owner was looking to implement a new process where the dispensing would be highly automated using two robots.

#### **What measures were taken?**

The pharmacy owner asked for feedback from a wide range of patients, including people sharing protected characteristics. This was to make sure that any changes would not adversely affect their ability to access pharmacy services. The owner also carried out an equality impact assessment.

The pharmacy developed procedures to make sure it could adequately identify any issues once the changes had been made.

All services were risk assessed before the changes, and regularly afterwards to make sure that risks were managed.

Improvements have been demonstrated by comparing the new services and technology with the previous arrangements.



### 1.3 Staff with clearly defined roles and accountability

Pharmacy owners are responsible for making sure that pharmacy services are provided by staff with clearly defined roles and clear lines of accountability. There should be transparency and fairness when it comes to allocating roles or promoting staff, and when applying policies in the pharmacy.

In the spirit of fairness and proportionality, it is good practice to put in place policies and procedures which consider the size and circumstances of your pharmacy.

You should consider developing a clear equality policy for your staff and the people using your services. This demonstrates good equality practice and lets everyone know that this is something you take seriously. It clearly shows your staff, as well as patients and members of the public, that you are committed to equality and diversity in everything you do as an employer and service provider.

Your policy should spell out your commitment to the principles of equality, as well as setting out any legal requirements. A statement of this kind usually defines your workplace culture and could clearly set out that discrimination and harassment will not be tolerated in your pharmacy. It should cover every aspect of running a pharmacy, from recruitment through to pay, benefits, training, management, discipline and grievance procedures.

You should make sure that your staff understand their equality obligations by giving them specific training. This training should cover:

- equality law
- the protected characteristics
- a definition of acceptable and unacceptable behaviour
- their personal responsibilities, and
- your equality policy

Staff also need to be aware of the requirement to follow the NHS **Accessible Information Standard**, which aims to make sure that people who have a disability, an impairment or sensory loss are provided with information in an accessible format, and supported to use it.

You should also consider other training that could be useful and appropriate, including training about cultural competence and decision-making. Cultural competence means being able to understand and interact with people in a way that recognises and respects diversity and cultural differences, including values, beliefs and behaviours. This includes:

- a willingness to learn about the cultural practices of other people
- having a positive attitude towards cultural differences, and
- a readiness to accept and respect cultural differences

Cultural competence is especially important when providing services to diverse communities and groups.

Staff who understand their roles and responsibilities in relation to equality can provide a good service, make informed decisions, and feel able to raise concerns if they need to.

The following example shows how pharmacy owners can meet the requirement to have staff with clearly defined roles and clear lines of accountability. It may not apply in all situations and there may be other ways to meet this requirement.

### ***Example: Staff with clearly defined roles and accountability***

#### **What is the challenge?**

Patients have reported that they are not always clear on the roles, qualifications and expertise of pharmacy staff. If patients have an issue or need to ask for advice, they would like to easily identify the correct member of staff.

This is especially true for people with learning disabilities, who benefit from clear, simple, and possibly repeated explanations and instructions.

#### **What measures were taken?**

The pharmacy displayed photos of staff responsible for specific services, along with their job titles, to help people using those services.

The owner made sure that staff had received equality training and were able to identify people coming into the pharmacy who might need extra support.

### **1.4 Openness to feedback and action on concerns**

Pharmacy owners should be willing to listen to staff and patient feedback and concerns, and take these into account when appropriate. This includes any reports of unfair treatment and discrimination. As an employer, you are legally responsible if your staff carry out acts of discrimination, harassment and victimisation during their work. You can prevent this behaviour if you tell your staff what is expected of them and how equality law applies to what they are doing. Ways to tell them about equality law would include your equality policy, dedicated equality training and their terms of employment. If you use these, you will be able to show that you have taken reasonable steps to prevent unlawful discrimination and harassment.

If someone does complain, you should investigate what has taken place. If appropriate, you may also need to discipline the person who has unlawfully discriminated against or harassed someone else.

You should have a clear complaints policy, to make sure that you deal with all complaints – including those of discrimination, harassment and victimisation – promptly, fairly, openly and effectively.

### **1.5 Appropriate indemnity or insurance arrangements**

To keep to equality legislation, all organisations providing goods, facilities or services to the public must consider making 'reasonable adjustments' to their practices and the services they deliver. The duty to make reasonable adjustments aims to make sure that disabled people can experience services to a standard as close as possible to that usually offered to non-disabled people.

A pharmacy could provide reasonable adjustments for older people or disabled patients who need to take medication by giving them 'compliance aids', such as:

- 'easy open' containers
- multi-compartment containers, divided into days or parts of days
- reminder charts
- alarms (such as notifications on mobile phones)
- dexterity aids, for example to help open jars

- winged or plain bottle caps

However, you shouldn't assume that a patient will necessarily benefit from a particular adjustment. It is important to establish what the need is, the suitability of an adjustment, and the preference of the patient.

Once an adjustment has been made, the pharmacy and the pharmacist are responsible for it. If the adjustment causes harm, this could lead to professional liability and indemnity claims against the pharmacy. Examples of harm include: a reminder chart that the patient is not able to understand, or a monitored dosage system which results in incompatible medicines being given or a deterioration of the medicines.

### **1.6 Maintaining all necessary records for the safe provision of pharmacy services**

You must make sure that you keep and update all pharmacy records required by law – including any that you need to meet your equality obligations. This will demonstrate that services in your pharmacy are provided safely and effectively.

### **1.7 Protecting the privacy, dignity and confidentiality of patients and the public**

Pharmacy owners should make sure that sensitive information is managed to protect the privacy, dignity and confidentiality of your staff, patients and members of the public who receive pharmacy services.

This is particularly important for EDI information. This information is sensitive personal data and individuals always have a right for it to be kept confidential and protected. For example, if members of the pharmacy team are aware of an individual's medical history or circumstances, they should ask the person for permission before passing this information on to someone else.

You should also take the greatest care with your staff's EDI information. Monitoring the profile of your staff, although you do not need to do this by law, will demonstrate your commitment to equality. It can also help you understand the make-up of your workforce and their different needs, as well as show you areas for improvement.

You should collect only the information that you can use effectively. You should also have a statement which makes it clear to your employees, and any new job applicants, why you are collecting this information. You should have effective procedures in place to control how equality information is collected, stored, and analysed. You must make sure that the information collected is processed fairly and lawfully, and in line with the **Data Protection Act 2018**.

You may decide to collect anonymous information, and this might mean people are more likely to volunteer their data. In any case, you need to reassure them that the information they give will never be used to discriminate against them.

### **1.8 Safeguarding children and vulnerable adults**

You will find that your responsibilities under equality legislation overlap with the need to safeguard vulnerable service users.

You should consider whether you have the right systems and policies in place to handle confidential information and communicate with any relevant agencies. You should also consider whether you provide the right environment where patients and members of the public feel safe to share concerns and disclose personal information.

Safeguarding issues can arise in different circumstances and can affect several groups, including:

- children and older people

- women, who may or may not be pregnant, and
- transgender people

They could also affect people based on their race, religion or sexuality. Being able to spot warning signs and take appropriate action is a key part of your pharmacy providing safe and effective services to patients and the public.

The example below shows how pharmacy owners can meet the requirement to protect the privacy, dignity and confidentiality of staff, patients and the public. It may not apply in all situations and there may be other ways to meet this requirement.

### ***Example: Safeguarding children and vulnerable adults***

#### **Context**

The pharmacy provided a range of extended services for people with dementia and their families.

There were many patients in the community suffering from dementia of varying degrees. So, the pharmacy identified the need for improved local provision and improved knowledge among staff, patients and carers.

#### **What measures were taken?**

One of the pharmacists decided to undertake personal training and development, and became involved with other healthcare professionals – including specialists – on a dementia project.

The pharmacist developed a checklist of areas to consider in pharmacies to make them 'dementia friendly', to be used at first in their own pharmacy. This was later developed into a 'toolkit' for all pharmacies to use, which included: training material for pharmacy staff, agencies to refer patients to, and an audit to assess pharmacies' 'dementia friendliness'. The toolkit was shared with the Royal Pharmaceutical Society, and it was also used by a university and trialled in some local pharmacies.

The pharmacy linked with Alzheimer's Scotland and all staff in the pharmacy were trained by one of their outreach workers.

The pharmacy set up a weekly drop-in clinic for patients, carers and families. This allowed them to get support and access to other services and was well attended and became very popular.

Local businesses regularly referred their customers to the pharmacy. The pharmacy also won an award for the Best Independent Community Pharmacy for Innovation for their work in dementia care.

## **Principle 2: Staff are empowered and competent to safeguard the health, safety and wellbeing of patients and the public.**

### **2.1 Enough suitably qualified and skilled staff**

The number of staff and the skill mix needed for the safe and effective provision of services depends on the size, workload, and context of your pharmacy. However, it is important that there is a staffing plan, including any contingency plans. You also need to have regular reviews of the staffing levels and the skills and qualifications needed by staff members. This should include considerations about equal opportunities for candidates to apply for and get different roles or positions, making sure that people are not disadvantaged or discriminated against because of a protected characteristic.

Equality law allows you, as an employer, to take ‘positive action’. Positive action is the term used for measures allowed under the Equality Act to put right the disadvantage or under-representation experienced by people who share protected characteristics. These apply in the workplace, and – in specific cases – in the provision of goods, facilities or services. There are also statutory conditions that you must meet before applying positive action measures.

The law also distinguishes between positive action (which is lawful) and positive discrimination (which is unlawful).

An example of positive action would be if the make-up of your team was different to the make-up of the local population, and you wanted to encourage more candidates who shared a particular protected characteristic to apply.

We strongly recommend that you read and carefully follow the **advice from the Equality and Human Rights Commission (EHRC) on positive action**, so you can get this right. The guidance includes examples of different forms of positive action and when you might use these.

## **2.2 Staff with appropriate skills, qualifications and competence for their role and the tasks they carry out**

You are responsible for making sure that all staff are properly trained and competent to provide medicines and other pharmacy services safely and effectively. This includes equality training.

As an employer, you must make sure that the opportunities you offer for training and development are free from unlawful discrimination. When deciding on training opportunities, focus on the individual needs of your team members, rather than on their protected characteristics and your assumptions about these. For example, when considering training, do not overlook pregnant women or people on maternity or paternity leave.

Try to be flexible about the training opportunities you provide to your employees. This means making sure that the style, timing or location of the training does not put anyone who shares a protected characteristic at a disadvantage.

The following example below shows how pharmacy owners can meet the requirement that all staff are properly trained and competent to provide medicines and other pharmacy services safely. It may not apply in all situations and there may be other ways to meet this requirement.

### ***Example: Staff with appropriate skills, qualifications and competence for their role***

#### **Context**

The pharmacy owner made sure that their induction and training programmes reflected their EDI commitments, and supported staff in identifying and achieving their learning goals.

#### **What measures were taken?**

A comprehensive induction programme was in place for new members of the team, which covers the pharmacy’s equality and diversity, whistleblowing, and complaints policies.

There was a programme in place where newer team members could shadow more experienced colleagues when learning various tasks. The pharmacy had also introduced a ‘buddy’ system to support colleagues in training roles.

The superintendent pharmacist led regular training sessions with all the team, and pharmacy team members had access to different training modules. Pharmacy team members regularly shared information on healthy living topics and held regular conversations and team meetings.

The pharmacy had 'training request' forms which team members could use if they wanted any specific training or further support. Team members could say if they would benefit from one-to-one learning and if they were able to do extra training outside their contracted hours. This allowed flexibility for employees and catered for disabled people and people with religious commitments or caring responsibilities.

The decision by the pharmacy owner to invest time and effort in staff training meant that staff were well placed to provide safe and effective services to patients and the public, and that they treated everyone with dignity and respect.

### **2.3 2.4, 2.5 Empowered staff and an open learning culture**

As the pharmacy owner, you are responsible for making sure staff can always meet their own professional and legal obligations. They must feel able to provide feedback and raise concerns – including about discrimination – without fear of harassment or victimisation.

The culture in your pharmacy will depend on your leadership. If you demonstrate your commitment to equality and human rights from the start of their employment and make it part of your organisational culture, your staff will feel motivated. You will also be able to attract and keep valuable workers. If treating everyone with dignity and respect is the way of doing things in your pharmacy, you are much less likely to have a case of discrimination, bullying or harassment brought against you and your team.

If you have an open and inclusive culture, free from harassment and prejudice, you will have a committed pharmacy team who apply the principles of equality and human rights in their work.

If a member of your team wants to complain about discrimination, they might raise this with you, or make a claim in an Employment Tribunal. It would be in your interests to avoid the latter, which could be lengthy, costly, and damaging to your pharmacy's reputation. You could avoid this by making your staff confident that their complaints about discrimination will be taken seriously. They should know how to raise a concern – informally, or by using a set grievance procedure – and know that there would be consequences if someone has discriminated unlawfully. They should also feel able to get advice from within the pharmacy, or from outside (from unions, charities, the GPhC or other bodies), before deciding whether or not to raise a concern.

The following example illustrates how pharmacy owners can meet the requirement to make sure staff can always meet their own professional and legal obligations. It may not apply in all situations and there may be other ways to meet this requirement.

#### ***Example: Empowered staff and an open learning culture***

##### **What is the challenge?**

A concern was raised by a member of staff about the unprofessional and discriminatory behaviour of one of their pharmacist colleagues. This was based on observation of the pharmacist's attitude towards the complainant and others. The complainant reported experiencing distress due to the behaviour of the pharmacist in question.

##### **What were the measures?**

The pharmacy owner investigated the complaint by speaking with other members of the team and the registrant in question and by observing their behaviour. They then took the steps needed to deal with the concerns raised. These steps included getting a formal apology for the complainant and providing them support for their mental health. The complaint was also recorded on the pharmacist's file. All of the team received refresher training on equality and a reminder about the different ways of raising a concern, for both employees and members of the public. They also received support with their mental health.

The pharmacy owner had to decide whether disciplinary action was necessary. They decided that the steps that had already been taken – which included the additional training and the apology – were appropriate in this case.

### **Principle 3: The environment and condition of the premises from which pharmacy services are provided, and any associated premises, safeguard the health, safety and wellbeing of patients and the public.**

You must make sure that your pharmacy premises are safe and suitable for providing services to patients and members of the public. When planning and reviewing the suitability of your premises, you should take account of the needs of people with different protected characteristics, including those with mobility or comprehension issues.

You must make sure that nobody is unlawfully discriminated against, harassed or victimised when using your premises. This partly depends on the awareness and attitude of your staff. But it is also affected by the environment in your pharmacy, and how it works to protect the privacy, dignity and confidentiality of the people you serve.

You will see examples of what pharmacies have done in this area in the box below. These may not apply in all situations and there may be other ways to make sure you meet this requirement.

#### ***Example: The environment and condition of the premises***

- A pharmacy provided private booths for COVID-19 vaccinations. This helped protect people's privacy and dignity if they needed to remove any items of clothing before being vaccinated.
- Cordless phones were used in one pharmacy to allow staff to hold private conversations away from the public area. This was particularly important for people wanting to discuss sensitive issues, such as:
  - aspects of their long-term condition
  - gender reassignment, or
  - the impact of religious fasting on their health and wellbeing
- The consultation room in a pharmacy was an appropriate size to accommodate people, as well as their carers, parents or chaperones. Its door was wide enough to allow access for people with mobility difficulties. The room was clean, clutter free and well signposted for the convenience of people with cognitive or visual impairments. Its use was routinely promoted by pharmacy team members to people visiting the pharmacy.
- One pharmacy had a number of systems in place to get regular feedback from patients. This included a yearly survey, as well as anonymous feedback from regular 'mystery shoppers'. The pharmacy team reviewed the results from the surveys, and used the feedback to improve the layout and design of the pharmacy. This had recently included:
  - installing an automatic door to improve accessibility
  - a dedicated seating area for people waiting for services
  - installing a suitably sized consultation room, and
  - a separate 'consultation pod'

This allowed the pharmacy to deliver its services in a private and confidential manner.



## **Principle 4: The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public**

### **4.1 Accessible pharmacy services**

You are responsible for making sure that your services are accessible to patients and the public. This is not just about the physical accessibility of your premises. It also means your services must be available and provided adequately, at the right time, in the right place, and in the right way.

A thorough and ongoing risk and equality impact assessment will allow you to assess the accessibility of your pharmacy premises, and consider any reasonable adjustments you may need to make.

You may also consider adjustments for people sharing one or more of the protected characteristics – for example, older people visiting your pharmacy, or pregnant members of staff.

You should think about every aspect of your premises, including:

- how people enter and find their way around in the pharmacy
- how people communicate with staff
- any signs and information you provide
- any desks, counters and waiting areas

If you provide some or all of your services over the internet, you also need to think about the accessibility of your virtual ‘premises’ – your website – and make sure it is free from discrimination. For example, you mustn’t allow any discriminatory information or advertisements to appear on your website, and you must make reasonable adjustments to make sure that your website is accessible to disabled people.

#### ***Examples: reasonable adjustments***

- Providing lifts, wide or automatic doors, handrails or ramps for people with mobility issues
- Parking spaces set aside for disabled people
- Providing ‘tactile’ signage, for example signs with braille or raised print, and printed information in different formats for people with visual impairments
- Providing a hearing loop system for people with hearing impairments
- Making sure the entrance and exit are a different colour from other doors, or easily identifiable in some other way by people entering the pharmacy. This will help visually impaired and partially sighted people, as well as people with learning disabilities
- Making sure there is clear signage in the pharmacy
- Providing clear instructions and individual help for people with learning disabilities, with things such as filling in forms
- Using pictograms to help people with learning difficulties or people who speak other languages
- Using translation/interpreting services for people whose use of English is limited.
- If you have a website, providing text-to-speech software for people with visual impairments. You could make other adjustments to meet the needs of people who cannot use a mouse, and for people with dyslexia and learning difficulties.

The following example shows how pharmacy owners can meet the requirement to make sure services are accessible to patients and the public. It may not apply in all situations and there may be other ways to meet this requirement.

### ***Example: Safe and accessible pharmacy premises***

#### **Context**

This shopping centre pharmacy carried out targeted risk assessments and considered the needs and make-up of its local community, to make sure there was easy access to its premises and services.

#### **What measures were taken?**

There was good physical access to the pharmacy by a flat entrance which opened onto a flat shopping centre. Wide aisles allowed prams, wheelchairs and disabled people to move about easily in the pharmacy. There was a low reception desk at the end of the dispensary which allowed wheelchair access. This allowed patients to reach a desk to sign prescriptions and receive their medication.

There was a hearing loop system, and staff had strategies to make sure patients with hearing impairments understood how to use their medicines.

Large-print labels and large-print direction sheets were supplied for people who needed them. Other strategies used to help patients included:

- labelling some eye drops on the bottle and some on the carton so that patients could easily tell them apart
- supplying tablets that were cut in half, and
- repackaging tablets from plastic blisters into bottles with plain tops

All these strategies were risk assessed and the patient medication record (PMR) was noted to make sure medications were always supplied in this way.

## **4.2 Safe and effective pharmacy services**

Having an equality policy in place and making sure that everyone involved in delivering services has had equality training will help avoid unlawful discrimination and promote equality. Members of your team will be aware of the principles of equality and be aware of the need to provide more time, targeted care, or adequate help to people who need it.

You are also responsible for making sure that your pharmacy services are inclusive, and responsive to the diverse needs and cultural differences in the communities you serve. You must be satisfied that:

- people sharing any of the protected characteristics are not disadvantaged, and
- the care they receive is not compromised by gaps in your service provision or by a lack of awareness of their specific needs

You could consider adding clear visual signs, such as inclusivity posters, to make sure that everyone feels welcome in your pharmacy, and to reassure them that they will be treated with dignity and respect.

Pharmacies are in a unique position, compared to other health and care services. They are in the heart of local communities and are best placed to spot and deal with health inequalities among the local population. These unfair and avoidable differences in physical health outcomes, mental wellbeing and life expectancy have been made worse by the COVID-19 pandemic.

You are able to assess the needs of people coming into your pharmacy every day and the issues they are facing. These may be specific to certain socio-economic or ethnic groups.

Your role in tackling health inequalities could involve a targeted and better-informed use of primary care and public health services and prevention initiatives. This includes, for example, accessing commissioned interpretation and translation services when treating NHS patients, or using other commercial services. It could also involve the support of local community and faith leaders and use of your staff's own expertise and cultural awareness. For example, their ability to speak languages commonly used in the area can help remove language and communication barriers and deal with varying levels of literacy.

Using staff who speak other languages can help make sure that people receiving pharmacy services have the information they need, in an accessible way, about their medication and how to take it. However, when using staff or the local community to remove language and communication barriers, it is important to identify and manage the risks. You should consider whether the level of proficiency in the language allows for accurate interpretation especially when technical terms are used. For example, the directions for inserting pessaries and suppositories. You should also consider whether the privacy, dignity and confidentiality of people using your services can be maintained.

Something common to pharmacies that provide excellent and outstanding services is how person-centred they are. Staff are willing to listen to people, and to identify and respond to their current and prospective needs. For example, if you become aware that certain groups of people face a disadvantage, you will demonstrate good practice if you take positive steps to address their needs.

As with everything you do, we expect you to use 'due diligence' and have the right governance arrangements in place to support all your actions.

The following example shows how pharmacy owners can meet the requirement to provide safe and effective pharmacy services. It may not apply in all situations and there may be other ways to meet this requirement.

### ***Example: Safe and effective pharmacy services***

#### **Context**

The pharmacy worked with local and other stakeholders to identify and attempt to overcome the barriers to COVID-19 vaccination among groups within ethnic minority backgrounds.

#### **What measures were taken?**

The lead pharmacist worked with local community leaders to identify places that could be used as 'outreach clinics' where people could get vaccinated. As people already trusted their local leaders, they were more likely to use the outreach clinics.

As a result of these conversations, the lead pharmacist worked with NHS England to change their contract so the vaccination could take place in the different sites they had arranged.

The pharmacist also worked with the local media to counter 'fake news' from social media, and deal with historical myths and nervousness among the community. This was to try to increase the uptake among some people with ethnic minority backgrounds.

People using the service were provided with a private space for vaccination, which preserved their dignity. They could also choose to be vaccinated by someone of a particular gender. There were pharmacy team members who spoke different languages, so they could explain the process if English was not the person's preferred language.

**Principle 5: The equipment and facilities used in the provision of pharmacy services safeguard the health, safety and wellbeing of patients and the public.**

Just like with your pharmacy premises, the equipment and facilities used in your pharmacy must be safe and suitable for providing pharmacy services. This includes any equipment and facilities you use as reasonable adjustments to meet the needs of patients, service users and your staff.

In the case of adjustments made for your staff, whether these are linked to disability or another protected characteristic (for example, pregnancy), it is a good idea to discuss these with the specific member of staff to make sure they are suitable and effective.

## Other useful sources of information

Advisory, Conciliation and Arbitration Service (ACAS)

- [acas.org.uk](https://www.acas.org.uk)

Care Quality Commission (CQC)

- **How can a focus on equality and human rights improve the quality of care in times of financial constraint?**
- **Declare Your Care: People from black and ethnic minority communities**

Commission on Race and Ethnic Disparities

- **The report of the Commission on Race and Ethnic Disparities (2021)**

CPPE

- **Culturally competent person-centred care**

Diverse Cymru

- **diverse.cymru.org.uk**

Department of Health and Social Care (DHSC)

- **NHS Staff Management and Health Service Quality, Independent report (2011)**

Equality and Human Rights Commission

- **Equality Act guidance**
- **Public Sector Equality Duty**
- **What are reasonable adjustments?**
- **Equality impact assessments**

Equally Ours

- **equallyours.org.uk**

General Pharmaceutical Council (GPhC)

- **Delivering equality, improving diversity and fostering inclusion: our strategy for change 2021 – 2026**
- **GPhC knowledge hub**

The Health Foundation

- **Ideas into action: person-centred care in practice** (2014)

Health and Safety Executive

- **[hse.gov.uk](https://www.hse.gov.uk)**

Health Watch

- **COVID-19: What can pharmacists learn from people's experiences of services?** (2021)

Legislation.gov.uk

- **Equality Act 2010**

LGBT Foundation

- **Hidden Figures: LGBT Health Inequalities in the UK** (2020)
- **Good practice guide to monitoring sexual orientation and trans status** (2021)
- **Hidden Figures: The impact of the COVID-19 pandemic on LGBT communities in the UK, May 2020, 3rd edition** (2020)

National Dignity Council

- <https://www.dignityincare.org.uk/>

National Literacy Trust

- **Adult literacy**

NHS England

- **NHS Accessible Information Standard**
- **Guidance for Commissioners: Interpreting and Translation Services in Primary Care** (2019)

NHS X

- **NHS Records Management Code of Practice** (2021)

NHS Scotland

- **Interpreting, communication support and translation national policy** (2020)

Nuffield Trust

- **Ethnicity coding in English health service datasets** (2021)

Nursing and Midwifery Council (NMC)

- **The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process** (2017)

Pharmacist Support

- **pharmacistsupport.org**

Pharmacists' Defence Association

- **the-pda.org**

PSNC

- **PSNC Briefing 01/16: Equality Act 2010** (January 2016)

#### Public Health England

- **Pharmacy and people with learning disabilities: making reasonable adjustments to services** (2017)
- **Language interpreting and translation: migrant health guide** (2017)
- **Reducing health inequalities: system, scale and sustainability** (2017)
- **Pharmacy teams – seizing opportunities for addressing health inequalities**

#### Royal Pharmaceutical Society

- **Joint National Statement of Principles on Inclusive Pharmacy Professional Practice** (September 2020)
- **Joint National Plan for Inclusive Pharmacy Practice in England** (March 2021)
- **Improving Inclusion and Diversity across our profession: our strategy for pharmacy 2020 – 2025**

#### The Diversity Trust

- **[diversitytrust.org.uk](https://diversitytrust.org.uk)**

#### The Equality Trust

- **[equalitytrust.org.uk](https://equalitytrust.org.uk)**

#### Welsh Government

- **More than just words: Welsh in the workplace** (2019)



# Fitness to practise hearing format guidance: Deciding whether a fitness to practise hearing is remote or in-person

## Meeting paper for Council on 10 November 2022

Public

### Purpose

To present to Council the proposed Fitness to practise hearing format guidance: Deciding whether a fitness to practise hearing is remote or in-person.

### Recommendations

The Council is asked to agree the guidance document at appendix 1.

#### 1. Introduction

- 1.1 The GPhC started holding remote fitness to practise hearings at the start of the pandemic lockdown in March 2020. This approach was enabled by a temporary amendment to the GPhC's statutory procedural rules, which provided the GPhC with greater flexibility in performing its statutory functions, in response to the challenges brought about by the Coronavirus pandemic.
- 1.2 At that time fitness to practise hearings would only be held remotely where registrants agreed to a remote fitness to practise hearing and the GPhC deemed it appropriate for the case. That approach has remained the case up until the current time.
- 1.3 The positive anecdotal feedback the GPhC received about holding remote fitness to practise hearings since March 2020 persuaded the GPhC to seek permanent amendments to the GPhC rules to enable a fitness to practise hearing to be held in-person or remotely where it is fair and appropriate to do so.
- 1.4 In line with the GPhC's duty to consult before making any changes to its rules, under article 66 of the Pharmacy order, the GPhC conducted a 12-week public consultation between the 16 November 2021 and the 8 February 2022.
- 1.5 There were over 500 responses to the consultation with over 90% being supportive of holding some fitness to practise hearings remotely, whilst also identifying some issues for the GPhC to consider in ensuring the format decided is fair in individual cases. The full analysis of the consultation was provided at the May 2022 Council meeting.

- 1.6 The GPhC Council agreed and made a rule change in May 2022 to permanently allow the GPhC to hold remote fitness to practise hearings. At the May 2022 Council meeting a commitment was provided to review and update the existing guidance on determining the format of a fitness to practise hearing to taking into account issues raised in the consultation responses.
- 1.7 The updated legislation has now been formally approved by the Privy Council and has been simultaneously laid in the Westminster and Scottish Parliaments. The updated rules came into force from the 1 October 2022.

## 2. New Guidance

- 2.1 As agreed at the GPhC's May 2022 Council meeting, the GPhC has reviewed and updated the existing guidance on how to determine the format of a fitness to practise hearing in light of both the new rules coming into force and taking into account the issues raised in the consultation responses.
- 2.2 The updated guidance (Appendix 1 - *Fitness to Practise hearing format guidance: Deciding whether a fitness to practise hearing is remote or in-person*) sets out the criteria to consider in making a decision.
- 2.3 The proposed guidance has been reviewed and developed collaboratively between Adjudications and Fitness to Practise departments to ensure that processes is fair workable and efficient.
- 2.4 The review of the guidance, included:
  - Considering the points raised in the consultation analysis
  - Liaising with other health and social care regulators about their process
  - Reviewing other health and social care regulators guidance
  - Seeking views and feedback from the views from our Statutory Committee Chairs (who will ultimately make the decision on the format of hearings)
  - Seeking views and feedback from GPhC's Appointments and Assurance Committee.
  - Noting and considering the recommendations made by the PSA in their response to our remote hearing's public consultation.
- 2.5 As mentioned above the proposed process and guidance have been part informed by liaising with the other health and social care regulators and by researching what guidance was available on their websites. This included the General Medical Council, Nursing and Midwifery Council, General Dental Council, General Optical Council, General Chiropractic Council, Health and Care Professions Council, and General Osteopathic Council.
- 2.6 Most of the other regulators gather the registrant's and regulator's views on the hearing format during the scheduling process and will schedule the hearing as such if they're in agreement. Where there is a disagreement which can't be resolved between the parties a chair will be asked to make the decision. The regulators who don't follow this process use internal case management teams to decide the format of a hearing based on the case.

- 2.7 Therefore, whilst the proposed process and guidance are applicable to the specific nature of GPhC's practice and they also largely in keeping with the other health and social care regulators.
- 2.8 The GPhC's underpinning policy priority remains the need to ensure that regulatory justice of fitness to practise hearings can be delivered fairly and effectively. The delivery of that policy objective will also continue to be delivered in line with the GPhC's Managing Concerns strategy to focus on a person centre approach to regulation.
- 2.9 It is for both these reasons that the decisions on the format of a fitness to practise hearing will be taken on a case-by-case basis. If all else remains equal in these respects, then the format of the fitness to practise hearings should be determined by the effectiveness and efficiency of its delivery.
- 2.10 The key change to the process and guidance reflects that the new GPhC's rules require the Chairs of the Fitness Practise Committee to make the overall decision on the format of the hearings.
- 2.11 The summary of the proposed process is set out below:
- During the scheduling process for a Principal Hearing, the GPhC's case presenter and the registrant will be asked to complete listings questionnaires. The questionnaire directs parties to the Guidance so they can consider relevant factors about the case. This questionnaire asks about key information and whether each party wants the hearing to be remote or in person and brief reasons why.
  - Based on the information received the Adjudications team will write a recommendation on how the hearing should take place, outlining the key factors provided by the parties.
  - If parties are in agreement the recommendation will confirm that and a hearing will be listed as such.
  - Once the chair is empanelled, they will be sent this information to either confirm the format or request a Case Management Meeting (CMM).
  - If parties aren't in agreement the chair will be asked to decide the format at a CMM.
  - At the start of each hearing the Chair will confirm the format and that parties are content to proceed in that way.

### **3. Equality and diversity implications**

- 3.1 The GPhC are committed to ensuring that any guidance created is compatible with our commitment to equality, diversity and inclusion. It is important that all parties are able to engage in proceedings regardless of whether a fitness to practise hearing is remote or in person. People's needs and any adjustments required will be identified during the scheduling process and taken into account as part of the decision. People's ability to engage in proceedings and equipment/environments available to them is a factor to consider identified in the guidance.
- 3.2 A number of EDI issues were raised in the GPhC's public consultation including poor wifi connection, loss of body language and non verbal signs, people with disabilities, hearing impairments and visual impairments. Many respondents felt the GPhC's proposal would not have an impact on people sharing protected characteristics, with the exception of age,

disability, and pregnancy/maternity. Those for whom English is not their first language may struggle more with communication on remote fitness to practise hearings and may benefit from face-to-face hearings. We heard that some ethnic minority groups cohabit in extended families, which may mean remote fitness to practise hearings are not appropriate due to the lack of privacy and a quiet setting.

- 3.3 It's important to not make assumptions about participants at fitness to practise hearings, the format will be decided on a case-by-case basis. Our guidance and scheduling process allows the GPhC to engage with participants and identify information which may mean a remote or in person fitness to practise hearing is more suitable.

## **4. Communications**

- 4.1 The legislation came into force in October. The updated guidance will be published on the website and relevant parties will be directed to it. An update will be sent to chairs of the Fitness to Practise Committee and relevant representative bodies once this process has been agreed.

## **5. Resource implications**

- 5.1 The proposed process can be carried out as part of the Adjudications team's current scheduling process, no further resources are required.

## **6. Risk implications**

- 6.1 Putting in place a process for deciding whether a fitness to practise hearing should be held in person or remotely where parties do not agree, helps to mitigate the risk that the GPhC will be deemed by the PSA, High Court or any other entity to have acted unreasonably. There remains the risk that arbitrary decisions will be taken by chairs in making these decisions, but this can be mitigated through clear and extensive guidance as to the issues to consider and give weight to, and oversight of the decisions that are made to ensure compliance with the guidance.
- 6.2 As the decision on the format of fitness to practise hearing are taken on a case by case basis, ultimately by individual chairs, the guidance provides an important framework of the factors that need to be taken into account and help support consistent application of the approach.
- 6.3 There remains the risk that overriding the submissions of the registrant either way may result in an appeal. The GPhC usually has a medium/high risk appetite for legal challenge where we believe we assumed an appropriate position. The risk of legal challenge is offset against the resource implications of holding more in person fitness to practise hearings which may be a consequence of always agreeing with the registrant. There is also the issue of witnesses and what may facilitate their involvement. We consider that the position we have assumed, provided there is strong guidance and process in place, will ensure we manage any associated risk to within Council's risk appetite.

## **7. Monitoring and review**

- 7.1 Alongside usual reviews for guidance there is currently an ongoing project regarding quality in the fitness to practise hearings process. This work has involved workshops with relevant team members from across the organisation to determine what a good quality fitness to practise hearing looks like and to map our current controls against these to ensure we are set up to deliver this. The work is ongoing, but we anticipate a series of recommendations

coming out of this work to strengthen the process which can then be reviewed against the respective fitness to practise hearing formats.

## **8. Recommendations**

The Council is asked to agree the guidance document at appendix 1.

Lucy Eames, Adjudications and Partners Manager  
General Pharmaceutical Council

10/11/2022

# Fitness to Practise hearing format guidance: Deciding whether a fitness to practise hearing is remote or in-person

## Introduction

1. General Pharmaceutical Council (GPhC) legislation allows for fitness to practise hearings to take place either remotely or in person. The purpose of a fitness to practise hearing is for a committee to hear evidence and consider a case to ensure the fair administration of regulatory justice, as part of the GPhC's public protection work.
2. The GPhC seeks to achieve the fair administration of regulatory justice in a manner that implements the GPhC's Managing Concerns strategy which focusses on a person-centred approach to pharmacy regulation. Therefore, the decision as to the format of a fitness to practise hearing will need to be taken on a case-by-case basis. This means:
  - Parties must be able to engage in the fitness to practise hearing;
  - The format of the fitness to practise hearing must allow them to present their case as best they can; and
  - Fitness to practise hearings should be scheduled and completed as efficiently and effectively as possible.
3. The purpose of this document is to set out the criteria to consider when deciding the format for a fitness to practise hearing, remote or in person.

## Who this guidance is for:

4. The Adjudications team must take this guidance into account when scheduling a fitness to practise hearing. The committee chair must take this guidance into account when deciding on the format of a fitness to practise hearing. In accordance with the legislation the ultimate decision about the format is for a committee chair.

## Criteria to consider

5. A number of factors should be considered when deciding whether a remote or in person fitness to practise hearing would be most effective. This list of criteria is not exhaustive and the format of a fitness to practise hearing should be considered on a case by cases basis.

## Registrant's view

6. When scheduling a fitness to practise hearing the registrant will be asked whether they think it should be remote or in person along with brief reasons why. Registrants will have access to this guidance which includes the list of factors they may want to consider. Although the registrant's view will be taken into account, there may be competing factors which override the registrant's preferred format. In any case the format of the fitness to practise hearing will be communicated to the registrant with the reasons why.

## Complexity of the case

7. Complex cases are cases where there is more than one type of allegation, where there is a large volume of documentary evidence, where there are multiple witnesses, and where the fitness to practise hearing is at least five days. Complexity in itself should not be a bar to a remote hearing but should be considered alongside other factors.

## Equality, Diversity and Inclusion (EDI)

8. The GPhC is committed to EDI and as part of this the format of a fitness to practise hearing must take into account the needs of each participant. To ensure a fair hearing, information will be gathered as part of the scheduling process to find out the needs of individuals, including the impact of any disabilities or other vulnerability, and how best they can engage with proceedings. Other considerations include (but are not limited to) language or learning needs, wider health issues or caring responsibilities.
9. Information will also be gathered on whether there are any cultural factors that need to be considered that might impact either the ability of an individual to participate in proceedings or which could influence how effectively they can participate. This information will be taken into account when deciding on the format of a fitness to practise hearing and any special measures required will be put in place.

## Health cases

10. Health cases require particular consideration of the impact on and the ability of the registrant to manage with either attending in-person or managing with a remote fitness to practise hearing. The registrant might find it difficult to attend a fitness to practise hearing in person due to health issues. However, in contrast the demands of managing the IT could be more stressful than an in-person environment. The health issues might in themselves raise challenges to picking up on visual cues if having to engage through a computer or phone screen.

## **The type of allegation**

11. Conviction, caution or health cases where the allegation is focussed on a single or limited factual issue (the conviction or the health condition) are ordinarily shorter cases, where key factual issues are not in dispute and where any witness evidence is likely to be limited. On the other hand, a misconduct or Deficient Professional Practice (DPP) allegation might well involve a range of factual issues and therefore be more complex, which could mean an in-person fitness to practise hearing is more suitable.

## **The extent to which any facts are in dispute or agreed**

12. Whereas the decision on impairment and sanction is a question of judgement for the committee, decisions on disputed facts require proof to a civil standard. This in turn might involve consideration of complex witness, documentary and other evidence.

## **Whether the registrant is represented or not**

13. The challenges to a registrant who is unrepresented can be managed and supported by the committee, the committee secretary and the case presenter. Some registrants might find in person support more helpful however others may feel more comfortable engaging from a familiar setting such as at home.

## **Witnesses**

14. Where any issues remain in dispute and witness evidence will need to be considered, the background of the witness should be taken into account. Professional witnesses, for example, superintendents (SIs) or pharmacy inspectors, or expert witnesses should be in a better position than members of the public to manage the challenges of giving evidence by remote means. Where the witness is a member of the public or a patient, consideration will include the length and complexity of their evidence, and how much of their evidence is linked to other documentary evidence which they will need to be taken through.
15. Where the witness is a vulnerable witness further consideration should be given to how any support will be provided. As with health cases, the specific vulnerability might make a remote fitness to practise hearing more stressful and difficult to manage than in an in-person fitness to practise hearing. On the other hand, some witnesses might feel more comfortable giving their evidence remotely. In some cases GPhC staff may be able to travel to assist a vulnerable witness in giving evidence remotely.

## **Access to Information Technology (IT)**

16. For remote fitness to practise hearings it must be established that all parties have the IT capability to effectively engage. Consideration should be given to the IT equipment available to the parties and also to the internet access available to them. This should also include a consideration of the physical environment, for example, are they in shared accommodation, will they have sufficient privacy or freedom from noise and other distractions. It should be borne in mind that not all registrants or witnesses will have the necessary IT equipment or the confidence to use IT resources to be able to meaningfully engage in a fitness to practise hearing. In some



situations, the GPhC may be able to provide equipment and an appropriate location to join from. For remote participants the Adjudications team will offer videolink tests.

## Non-Principal Hearings

17. Interim orders, Reviews, Restoration and Appeal hearings will be scheduled remotely. These are shorter and less complex as no decision on facts are required. With interim order application hearings there is a requirement for these to be scheduled quickly to address public protection concerns.
18. For all these types of fitness to practise hearings the registrant, representative, case presenter or committee members can request them to take place in person providing reasons for the request. The request will then be considered by a chair.

## Principal Hearings

19. For Principal hearings the case presenter, registrant, and their representative (if applicable) will be sent a listings questionnaire which covers issues like witnesses, number of days and the format of the hearing with reasons. The listings questionnaire will need to be completed and returned by a certain date. Where parties are in agreement of the format, the Adjudications team will confirm this in a recommendation and the hearing will be listed as such. If the chair who is allocated to the hearing disagrees with the format, they can request a Case Management Meeting (CMM).
20. For cases where parties aren't in agreement regarding the format, the Adjudications team will write a recommendation based on the information provided in the listing questionnaire. This recommendation, along with the completed listings questionnaire, will be given to a chair to make the final decision on the format either on papers or at a CMM. This will then be confirmed with parties and a Notice of Hearing confirming the location will be sent at least 28 days prior to the start date.
21. At the start of each hearing the chair will confirm the format and that parties are content to proceed in that way.

## Changing the format mid-hearing

22. Although the format of a fitness to practise hearing, remote or in person, will be decided in advance, it should be considered at the end of each day and stage, how best to proceed the next day/stage.

# Professional Standards Authority: annual performance review 2021/22

## Meeting paper for Council on 10 November 2022

Public

### Purpose

To update the Council on the annual performance review.

### Recommendations

The Council is asked to note the outcome of the 2021/22 performance review.

#### 1. Introduction

- 1.1 The Professional Standards Authority (PSA) carries out an annual performance review of each of the ten health and social care regulators, assessing their performance against its Standards of Good Regulation.
- 1.2 This report looks at the GPhC's performance during the period March 2021-June 2022. The PSA has moved to a new performance review system which includes less intensive 'monitoring reviews' and fuller 'periodic reviews' every three years. As part of the change, regulators have also been moved to new reporting cycles. Our cycle has changed from March-February each year to July-June and so this report covers March 2021-June 2022. This was a 'monitoring review' year for the GPhC.
- 1.3 As our previous report was only received in December 2021, there were only six months in which we could react to the recommendations.
- 1.4 This was our third review against the updated Standards. These include general standards relating to information provision, the application of policies, EDI, performance reporting, corporate complaints, how we address learning from public enquiries and other relevant reports. The standards still also cover registration, education, fitness to practise and standards/guidance.
- 1.5 During the period covered by this report, the GPhC was still dealing with the effects of the Covid-19 pandemic.
- 1.6 The new-format, shorter report is attached as **Appendix 1**.

#### 2. Key findings

- 2.1 The PSA found that the GPhC met 15 out of the 18 Standards of Good Regulation.

- 2.2 All of the general standards were met, as were all standards relating to guidance/standards; education and training; and registration. Two of the standards for fitness to practise were met, while three were not. These were standards 15, 16 and 18 – the same standards which were not met in the previous two years. However, the report does note that there was significant improvement in relation to standards 16 and 18 and some improvement in relation to standard 15, as well as a positive direction of travel. It acknowledges that we have completed the action plan developed in response to the Authority's earlier concerns, that it takes time to embed and demonstrate the impact of changes and that the organisation shows continued commitment to addressing the issues in this area.
- 2.3 The report notes the extensive work carried out to implement reforms to the education and training of pharmacists and the adaptations to the quality assurance process. It also comments at some length on the issues with the June sitting of the registration assessment (see page 4 of the report) but notes the seriousness with which we have treated them and the actions being taken to prevent a repeat.
- 2.4 We were pleased to note that stakeholder feedback was largely positive, with the report noting that a number of organisations commented favourably on the way that the GPhC has engaged and worked with them.

### **3. Equality and diversity implications**

- 3.1 The standard relating to EDI ('The regulator understands the diversity of its registrants and their patients and service users and of those who interact with the regulator and ensures that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics') was met. The report notes that we demonstrated our commitment to EDI in our roles as regulator and employer – see page 2 of the report for details.
- 3.2 The PSA is reviewing its approach to assessing this standard and the criteria required to meet it may change as a result. Together with the other regulators, we are in continuing discussions with the Authority about this.

### **4. Communications**

- 4.1 The report has been published on the PSA and GPhC websites.

### **5. Resource implications**

- 5.1 Responding to the performance review once again required considerable staff resource. The revised process, whereby the PSA draws more information from regular data, scrutiny of our website, attendance at Council meetings and reading papers, did lessen the resource requirements but the demands were still significant, particularly for the FtP and Governance teams.
- 5.2 The PSA has now introduced regular meetings with each regulator which should reduce the amount of information that needs to be provided at the end of a review period. However, our 2022-23 performance review will be a full periodic review and we expect this to require considerable resource, particularly in supporting any audits. This has been factored into workplans.

## **6. Risk implications**

- 6.1 The PSA report provides constructive feedback on the GPhC's performance and it is important that we respond to it in order to improve the way we regulate, for the benefit of patients, the public and the profession.
- 6.2 The continued implementation of the FtP improvement plan, the strategy for managing concerns and the end-to-end review of the FtP process will allow us to build on the continuing improvement which the PSA has noted. It will be important to demonstrate further improvement in the next review.
- 6.3 The regular meetings which now form part of the review process should give us an opportunity to address any concerns as they arise and to explain more about the work we are doing.

## **7. Monitoring and review**

- 7.1 We will continue to monitor progress and developments in all areas of performance. Council will continue to receive regular information via the Performance Monitoring Reports and developing Board Assurance Framework. Further assurance about aspects of organisational performance comes from the audits which are carried out across the business and reported to the Audit and Risk Committee.
- 7.2 The next PSA performance review cycle started in July of this year and the report should be completed before the end of September 2023.

## **8. Recommendations**

The Council is asked to note the outcome of the 2022/23 performance review.

Janet Collins, Senior Governance Manager  
General Pharmaceutical Council

[Enter date final version signed-off]

## Our performance review process

We have a statutory duty to report annually to Parliament on the performance of the 10 regulators we oversee. We do this by reviewing each regulator's performance against our Standards of Good Regulation and reporting what we find. Our performance reviews are carried out on a three-year cycle; every three years, we carry out a more intensive 'periodic review' and in the other two years we monitor performance and produce shorter monitoring reports. Find out more about our review process [here](#).

This report covers the period 1 March 2021–30 June 2022.

## Key findings

- The GPhC demonstrated its commitment to equality, diversity and inclusion (EDI) in its work as a regulator and an employer with the launch of its new EDI strategy. Activity arising from the strategy this year included its public consultation on draft equality guidance for pharmacies.
- Work continues on the GPhC's education reforms and we received positive feedback about the way it is engaging with stakeholders in this area. The GPhC adapted its quality assurance process to allow time for education providers to introduce changes arising from the new education standards launched last year. Early feedback about the changes to the process is positive.
- Concerns have been raised about whether the GPhC's remit and approach to pharmacy inspections sufficiently address the risks in this area. The GPhC is engaging with the concerns and exploring how they can be addressed so we will be monitoring how it responds and manages the risks identified.
- Two separate sets of issues arose with the June 2022 sitting of the registration assessment this year. The delays on the day of the sitting, and the impact on candidates, were concerning but the GPhC is treating them seriously and taking a range of actions to remediate what happened and prevent it from happening again.
- The GPhC completed the action plan it developed to address our concerns about its fitness to practise function. It also launched its new fitness to practise strategy. We recognise the GPhC's continued commitment to address our concerns and the direction of travel remains positive. However, the timing of activities this year, coupled with the time it takes to demonstrate the impact of changes, means we have not yet seen tangible evidence that our remaining concerns have been addressed. We cannot yet say that Standards 15, 16 and 18 are met.

## Standards met 2021/22



General Standards	5/5
Guidance and Standards	2/2
Education and Training	2/2
Registration	4/4
Fitness to Practise	2/5
<b>Total</b>	<b>15/18</b>

## GPhC standards met 2019-21

2020/21	15/18
2019/20	15/18



**86,250**

**professionals on the register  
(as at 30 June 2022)**

**13,849**

**premises on the register  
(as at 30 June 2022)**

## General Standards

**The GPhC met all five General Standards this year.**

These five Standards cover a range of areas including: providing accurate, accessible information; clarity of purpose; equality, diversity and inclusion; reporting on performance and addressing organisational concerns; and consultation and engagement with stakeholders to manage risk to the public.

### Equality, diversity and inclusion (EDI)

The GPhC is working hard to improve EDI in its work as a regulator and as an employer. This year it:

- launched its new five-year EDI strategy<sup>1</sup>
- launched its new five-year fitness to practise strategy which has EDI considerations built into it and recognises the need to address overrepresentation of registrants from Black, Asian and Minority Ethnic backgrounds in fitness to practise proceedings
- implemented a Diversity Action Plan to support the recruitment process for its new Chair
- started reporting to its Workforce Committee on its ethnicity pay gap alongside ongoing reporting on its gender pay gap
- consulted on draft equality guidance for pharmacies
- continued to recognise there is differential attainment<sup>2</sup> in its registration assessment and made EDI a focus of accreditation visits while exploring how it can further understand the causal and contributing factors in order to address them.

We are currently reviewing our approach to assessing Standard 3 as part of our own organisational [EDI action plan 2022/23](#).

## Stakeholder engagement

This year, the GPhC:

- held five consultations, routinely reporting on the responses received and how it will act on those responses
- set up an 'online public panel' for non-registrants to understand what people think about pharmacy services and the GPhC's work.

Several organisations sent us positive feedback about the way the GPhC has engaged and worked with them. The GPhC was described as constructive, responsive, collaborative and willing to listen to concerns and suggestions for solutions. One organisation commented that a previously difficult relationship is now much improved.



***“We believe, particularly as the sector navigated the uncharted pandemic experience, that the GPhC have appropriately approached the challenges faced with a mindset of joint problem solving.”***

## Guidance and Standards

**The GPhC met both Standards for Guidance and Standards this year.**

The GPhC delayed its planned reviews of its *Standards for pharmacy professionals* and *Standards for registered pharmacies* so that the reviews can take account of new rules and standards<sup>3</sup> it will be creating for Chief pharmacists, Superintendent pharmacists and Responsible pharmacists. The delay to the planned reviews is reasonable in the circumstances but we will monitor any further delays.

The GPhC continues to identify and respond to emerging areas of risk by providing information to help registrants apply its standards. It updated its *Guidance on providing pharmacy services at a distance, including on the internet* and it publicised guidance on areas of risk, such as online prescribing services, the sale of codeine linctus and supplying valproate. It published new resources on the duty of candour, with input from leading providers of professional indemnity insurance. It is also carrying out work on the guidance available on the use of Multicompartment Compliance Aids and we are monitoring this work as it progresses.

## Education and Training

**The GPhC met both Standards for Education and Training this year.**

### Education reform

The GPhC is carrying out extensive work to implement reforms to the education and training of pharmacists. This year, it started the transition to its new *Standards for the initial education and training of pharmacists*, which launched in January 2021. It also introduced an interim set of learning outcomes for the new Foundation Training Year that started in July 2021.

The GPhC's Advisory Group is working closely with stakeholders across the UK to make sure areas of risk are identified and addressed and to ensure regular and consistent information is shared about the work. The Advisory Group is currently focused on:

- how training on independent prescribing will be incorporated into training programmes under the new Standards<sup>4</sup>
- quality assurance

- the evidence framework to support the new Standards
- the future of the registration assessment

We received largely positive feedback about the way the GPhC is engaging with stakeholders about the education reforms, although one stakeholder commented on the delay in introducing the evidence framework to support the new Standards.<sup>5</sup> The GPhC published other supporting resources in the meantime and we will monitor the work on the evidence framework together with the wider work being done by the GPhC on education reform.

### Changes to the quality assurance process

The GPhC adapted its quality assurance process so that the reaccreditation of existing courses against its new Standards is done in a proportionate way. Instead of using single reaccreditation events, the adapted methodology uses a two-stage process spread over a longer period of time to allow course providers time to implement the changes needed to meet the new Standards. It also takes into account that course providers are yet to receive confirmation of funding arrangements for delivering enhanced clinical activities, which may impact the approach taken by providers.

The GPhC will be evaluating the changes made to the process. We received early feedback that the adapted methodology is an improvement on the previous process.



## Registration assessment

### *June 2022 sitting of the registration assessment*

Last year we reported on issues that arose when the booking system went live for the March 2021 sitting of the GPhC's registration assessment.

The GPhC held several sittings of the registration assessment this year without similar incidents, including the first sitting of the common registration assessment with the Pharmaceutical Society of Northern Ireland (PSNI). However, two separate sets of issues arose for the June 2022 sitting, which was the first sitting run by a new provider:

- **May 2022:** despite successful system testing, when the booking system went live, technical issues meant it had to be taken down soon after. This led to a 24-hour delay in candidates being able to book a place and some test centres were overbooked, so 109 candidates had to be re-located.

The issues were rectified by the GPhC reasonably quickly and 2,900 candidates booked a place. The GPhC told us 'the overwhelming majority of candidates, including those who needed to be re-located, will be sitting the assessment at a test centre within reasonable travelling distance, most within 50 miles of their home.'

- **June 2022:** on the day of the sitting, technical issues caused delays at six test centres ranging from 45 minutes to seven and a half hours. After the sitting, candidates also reported several other types of concerns, such as individual allegations of cheating and background noise at test centres. The GPhC is investigating these reports.

### *How did the GPhC respond to the issues with the June 2022 sitting of the registration assessment?*

The GPhC recognised the seriousness of what happened and the impact it would have on candidates. It has so far responded in a range of ways, including:

- issuing several public apologies and signposting candidates to sources of wellbeing support
- convening an urgent Council meeting and establishing a new Council Committee on Quality and Performance Assurance to have oversight of the registration assessment<sup>6</sup>
- confirming candidates who experienced delays of 30 minutes or more will receive a full refund and the delays will automatically be accepted for grounds of appeal for candidates who did not pass
- re-opening provisional registration for candidates who had delays of more than 30 minutes or for candidates who successfully appeal on the basis of other procedural issues
- conducting a Serious Incident Review and commissioning an external audit of the registration assessment processes and contract with the new assessment provider
- meeting with a delegation of students who protested outside the GPhC offices and holding listening sessions for candidates to discuss their experience.

It is important that the GPhC avoids a repeat of what happened. We expect the GPhC to reflect on what happened and consider the outcome of the Serious Incident Review to identify where the failures occurred. We also expect the GPhC to consider whether the delays disproportionately impacted any candidates who share protected characteristics.



The issues that arose will likely have impacted confidence in the GPhC but we note they did not give rise to risks to public protection. We are satisfied that the GPhC responded to the emergency as well as it could have. We also note that this was the first sitting run by a new provider and other sittings took place during the review period without incident. What happened, and the impact on candidates, was serious, but the GPhC is taking steps to remediate this and prevent a recurrence. Consequently, we decided that Standard 9 was met.

### *Candidate performance in the registration assessment*

After each sitting of the registration assessment, the GPhC publishes an analysis of candidate performance by various categories, including schools of pharmacy and protected characteristics. The GPhC uses this analysis to identify concerns about education and training.

This year's data show ongoing concerns in two separate areas: differential attainment and the performance of one school of pharmacy. The GPhC is taking action in respect of both and we will be monitoring this activity. It is:

- as mentioned under the General Standards, working to understand the factors behind differential attainment so that measures can be taken to address it
- engaging with the school in question about improvements needed and considering whether any further action is necessary.

## Registration

**The GPhC met all four Standards for Registration this year.**

### Provisional register and temporary register

The GPhC closed its provisional register<sup>7</sup> on 31 January 2022 and will close its temporary register<sup>8</sup> on 30 September 2022. The GPhC

notified registrants of the planned closures in advance and encouraged them to apply for full registration to continue practising. This clear communication was important to ensure continuity of registration for those who wanted to keep practising.

### The GPhC's registration processes

The GPhC registers pharmacy professionals and pharmacy premises. We were told about some examples where people had a poor experience of the registration processes, in particular how long it took. These experiences do not appear to reflect the GPhC's overall performance during the review period because:

- the median time taken to process pharmacist applications from receipt of online application to approval was 29 days in Q4 2020/21 but was then within the GPhC's 28-day performance standard throughout 2021/22
- the median time taken to process premises applications from receipt of completed application to registration decision was two weeks for 2020/21 and 3.3 weeks for 2021/22.<sup>9</sup>

We will continue to monitor the GPhC's performance data, but we recognise the data in isolation does not always give a full picture of performance. Next year we will be interested in hearing more about people's experiences of the GPhC's registration processes.

### Revalidation

After reducing its revalidation requirements in response to the pandemic, the GPhC has put registrants on notice that it will be re-introducing the full requirements in October 2022. We will be monitoring any evaluation the GPhC undertakes of its revalidation requirements.

## Pharmacy inspections

The GPhC inspects pharmacies to ensure they meet its *Standards for pharmacies*. It reports on any enforcement action it takes and acts on any trends identified. This year, it:

- raised awareness of action it was taking against pharmacies in relation to the supply of codeine linctus
- updated its guidance for online pharmacies in response to a disproportionately high number of fitness to practise referrals received about these types of pharmacies.

Our register check identified instances of pharmacies meeting the Standards but having enforcement action taken against them. The GPhC explained there are several different circumstances where this situation might arise.<sup>10</sup> It has guidance in place to help it make consistent decisions about enforcement action. The GPhC's approach appears to be a reasonable and proportionate way of managing the risks in these situations. However, we encourage it to consider publishing information to explain why some pharmacies have met the Standards but are still subject to enforcement action.

We received feedback that raised concerns about whether the GPhC's remit and approach to pharmacy inspections address the risks arising in this area, with some examples highlighted to us:

- concerns that an investigation handled by the corporate owner of a pharmacy did not fall within the GPhC's remit
- clinical checks on prescriptions issued in instalments for periods up to 12 months not being carried out as they should be
- the use of artificial intelligence to replace pharmacist checks.

The GPhC is engaging with these concerns and responding to them by exploring how it can address them, both in the short and long term. We will be monitoring how it responds and manages the risks identified.

## Fitness to Practise

**The GPhC met two of five Standards for Fitness to Practise. The GPhC met Standards 14 and 17 and did not meet Standards 15, 16 and 18.**

### The GPhC's action plan

This year the GPhC completed the wide-ranging action plan it developed to address the concerns we reported about its fitness to practise function in 2018/19. Last year we saw evidence of some improvements, but we were yet to see evidence that the GPhC had fully addressed our concerns about:

- the transparency and clarity of its triage process and the impact of this on the fairness of the process and the quality of triage decisions
- the quality of threshold criteria decisions
- the timeliness of fitness to practise investigations
- the support provided to parties to participate in the process.

Activities completed by the GPhC this year included introducing:

- new *Initial assessment guidance* for the triage process
- senior sign-off and decision recording at triage for cases progressing to investigation, which are designed to improve recording of risk assessments and reasoning for decisions
- stand-alone decisions for cases closed at the end of the investigation stage, which are designed to improve the reasoning for decisions
- a new Investigation Planning and Report Form (IPRF) for use during investigations which is designed to support better recording

of risk assessments and reasons for decisions, including reasons for threshold criteria decisions

- its new fitness to practise strategy for managing concerns.

We recognise and welcome this work, which demonstrates a clear and continued commitment to addressing our concerns. However, we also recognise that it takes time to embed changes and demonstrate they have had the desired effect on performance. Next year we will assess in detail the impact of the GPhC's changes.

### Triage process

In recent years, we have been monitoring the triage stage of the GPhC's fitness to practise process because a high proportion of cases are closed at this stage and the GPhC's triage guidance did not properly reflect the process it was operating. The GPhC has been redesigning its triage function as part of its overall improvement work in fitness to practise.

We were pleased to see the GPhC introduce its new *Initial assessment guidance* as it more accurately reflects the GPhC's triage process. This should therefore address our concerns about the transparency and clarity of the process. However, the guidance only came into effect in the last month of the review period, so has had a limited impact on this year's performance review.

We received a small amount of feedback this year about the early stages of the GPhC's fitness to practise investigations, but we did not identify evidence of widespread concerns about the process. We will be interested in hearing more about stakeholders' experience of the process next year to help us assess the impact of the GPhC's improvement activity and new guidance.

### New fitness to practise strategy

The GPhC launched its new five-year fitness to practise strategy in July 2021.<sup>11</sup> It has four strategic aims designed to improve the fitness to practise process, the time taken to conclude investigations and the experience for participants. It is too early to see evidence of the impact of this wide-ranging work, but it demonstrates the GPhC's ambitions and ongoing commitment to improving performance in its fitness to practise function. We will monitor its impact in the coming years. One area of particular interest is the GPhC's intention to manage concerns outside its formal processes, such as through voluntary agreements. It is important that the GPhC uses these informal processes in way that is fair to registrants.

Time taken to progress cases

The GPhC is still taking too long to progress fitness to practise investigations. Figure 1 shows that performance against the median end-to-end timeframe declined this year, although there were improvements in the timeliness of other stages of the process.

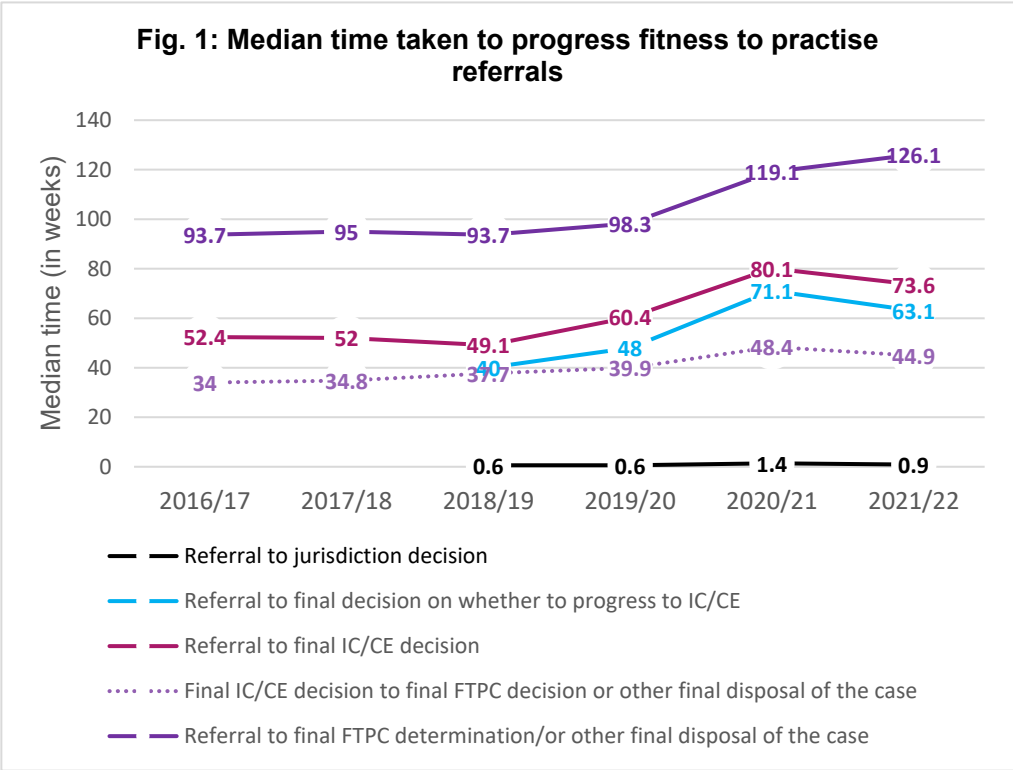
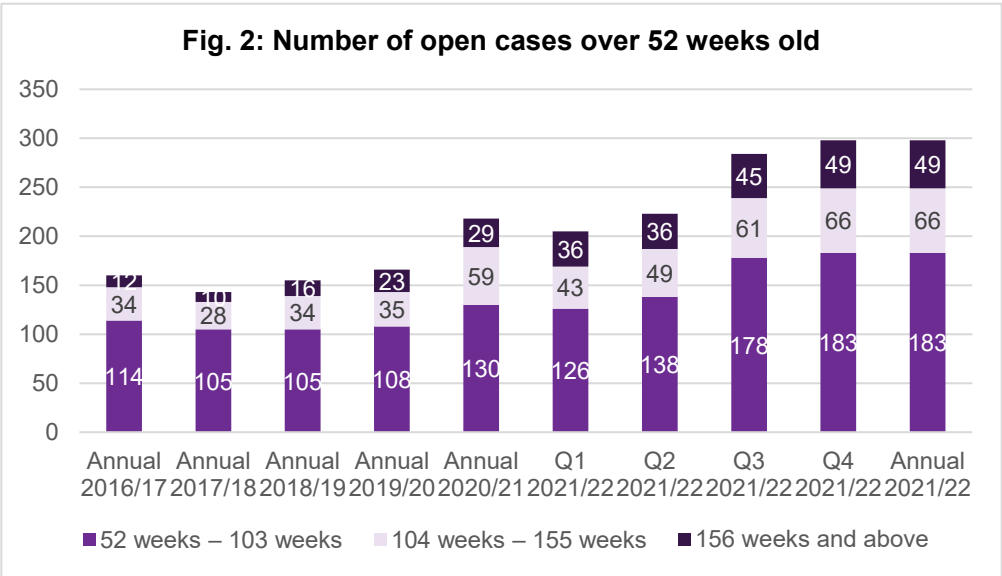


Figure 2 shows that the number of older cases also increased this year, despite an initial improvement in the first quarter of the financial year.



The GPhC recognises that it needs to improve the timeliness of case progression. It introduced several initiatives this year aimed at doing so, including:

- recruiting additional case officers and using additional administrative support to enable case officers to focus on progressing cases
- using external law firms to provide direction on complex cases
- completing an analysis to aid more accurate forecasting.

The GPhC has further work planned to improve timeliness and we welcome its commitment to this.

## Risk assessments

We have been concerned by the GPhC's documenting of risk assessments for a number of years. The GPhC accepts its risk assessments need to improve and we have reported in recent years on the steps it is taking to achieve this. Some of the changes mentioned above were also designed to assist improvements here, such as the new IPRF and the changes made for cases progressing to investigation. The GPhC also delivered training this year to its investigation teams on risk assessments and on giving good reasons.

The GPhC is monitoring and evaluating the impact of the changes it has made. It told us that a recent internal audit of closure decisions found improvements in risk assessments at triage.

We will continue to monitor the GPhC's risk assessments but have not seen evidence this year, or in previous years, that the issue is resulting in the GPhC failing to identify risks or serious cases. The data shows that the GPhC continues to promptly apply for interim orders after receiving information suggesting that one may be necessary.

## Support for parties to the fitness to practise process

The GPhC has been working to improve the support it provides to those involved in the FtP process since we reported concerns about this area in our 2018/19 report. The GPhC's plans were delayed by the pandemic, but it has now implemented a range of changes to improve customer service, including the launch of its new fitness to

practise strategy. We saw some improvements last year but some of our concerns remained.

The GPhC carried out a dip sample this year to look at the quality of its customer service. The findings suggest a positive direction of travel, but this is offset by what appears to be a small decline in performance since the introduction of the new investigation planning and report form. We also note that the sample size was relatively small and mostly focused on the earlier stages of the fitness to practise process, so we are not yet assured that our concerns have been fully addressed. We will continue to monitor the impact of the GPhC's changes as more evidence becomes available.

We recognise and welcome the GPhC's continuing commitment to addressing our concerns about its FtP process. These will take time to embed and we will assess their impact in detail next year. However, we concluded that Standards 15, 16 and 18 are not met this year.



### Quick links/find out more

- Find out more about our performance review process
- Read the GPhC's 2020/21 performance review
- Read our Standards of Good Regulation

<sup>1</sup> [Delivering equality, improving diversity and fostering inclusion: Our strategy for change 2021-2026](#)

<sup>2</sup> A difference in the average performance of groups who share a protected characteristic and those who do not share the same characteristic.

<sup>3</sup> The government is introducing two Section 60 Orders that will give the GPhC powers to create these new rules and standards:  
<https://www.gov.uk/government/consultations/pharmacy-legislation-on-dispensing->

[errors-and-organisational-governance/outcome/rebalancing-medicines-legislation-and-pharmacy-regulation-programme-consultation-outcome](#)

<sup>4</sup> Under the previous standards, independent prescribing training courses were standalone post-graduate courses.

<sup>5</sup> The GPhC's new *Standards for the initial education and training of pharmacists* were launched in January 2021 and the evidence framework was to be discussed by

the Advisory Group in September and October 2021 but the framework has not yet been published.

<sup>6</sup> The new Committee will also have oversight of other areas. Subject to Council approval, the draft Terms of Reference include the quality and performance of significant workstreams and improvement initiatives and the development of performance measures and data to provide meaningful updates to Council on the GPhC's performance and compliance with targets and plans.

<sup>7</sup> In response to the pandemic, the GPhC cancelled the 2020 sittings of the registration assessment. It then introduced a provisional register so that eligible trainee pharmacists could start practicing while waiting to sit the rescheduled assessment.

<sup>8</sup> In March 2020, the GPhC set up a temporary register so that eligible former registrants could join the workforce during the emergency situation created by the pandemic.

<sup>9</sup> The GPhC's guidance on applying to register pharmacy premises says it takes up to three months to process applications.

<sup>10</sup> For example, an inspection may result in a pharmacy not meeting standards and having conditions imposed on it, then at the follow-up inspection, the ongoing conditions continue to restrict certain activities but the pharmacy may be found to meet the standards in the areas that aren't restricted.

<sup>11</sup> [Managing concerns about pharmacy professionals: Our strategy for change 2021-26](#)

# Post registration assurance of practice

## Meeting paper for Council on 10 November 2022

Public

### Purpose

To provide information to council about the progress that has been made at the post-registration assurance of practice advisory group

### 1 Recommendations

The council is asked to note this information.

#### 1. Introduction

- 1.1 Following work undertaken by a short-life working group, Council agreed that the GPhC should take on a leadership role focusing on post-registration assurance of practice. This would build on some of the work previously done by the Education Governance Oversight Board and would consider a wider range of the educational regulatory, professional and governance arrangements that currently exist with a view to identifying where the quality assurance or any or all of these may need to be strengthened.
- 1.2 Council members Ann Jacklin and Aamer Safdar are co-chairing an Advisory Group of stakeholders and three meetings have now taken place to agree the purpose and terms of reference, the principles underpinning the work, the scope, and how the work will be taken forward.

#### 2. Purpose and principles

- 2.1 The purpose of the Advisory Group is: *“To allow the respective councils, GPhC and PSNI, to determine whether they are satisfied that the necessary quality control, quality management and quality assurance mechanisms exist for pharmacists and pharmacy technicians, post-registration, to protect the public and give them assurance that they will receive safe and effective care when using pharmacy services; and whether any additional assurance is required.”*
- 2.2 The principles underpinning the work are:
  - We must focus on protection of the public and patient safety as our priority to underpin all the work
  - The level and type of assurance must be proportionate taking account of the risk to public protection and patient safety and must also be pragmatic and achievable



- We must use a range of the best available insights and intelligence but predominantly robust evidence to inform our recommendations and to measure success
- We must involve patients and the public to help identify priorities and the level and type of assurance in addition to the views of the professions
- We must identify the appropriate organisation(s) to take responsibility for particular types of assurance
- We must determine appropriate recommendations, taking into account the context and changes in healthcare both now and in the future, to deliver effective and efficient outcomes

### 3. Scope of the work and how it will be taken forward

- 3.1 All stakeholders recognise that this is a large programme of work and we have therefore invested time to ensure that there is broad agreement on the scope of the work and the different mechanisms of assurance. The main drivers as to why this work is necessary reflect the rapidly changing healthcare landscape, notably: practice in providing enhanced clinical services, including prescribing; practice in new models of delivery, including online pharmacies and hub and spoke; practice in primary care due to rapidly developing roles; practice at different levels from newly qualified to advanced; and scope of practice for the pharmacy team as a whole due to workforce pressures and multi-professional working
- 3.2 The Group initially tried to prioritise these individually but recognised there is potential for considerable overlap so have brought them together under an overarching question: ***“How should assurance of post- registration practice be strengthened to take account of enhanced clinical practice, new models of delivery, rapidly changing roles and multi professional working across all pharmacy settings?”***
- 3.3 This will be assessed through the lenses of the following levers which will be taken forward in three phases to manage the work effectively:
- **Education and training (phase 1)**
  - **Revalidation and annotation (phase 2)**
  - **Governance and contractual arrangements (phase 3)**

### 4. Task and finish Group

- 4.1 A task and finish group is now being established to take forward phase 1 consisting of pharmacists and pharmacy technicians with knowledge of the education and training landscape and front-line practice. GPhC will lead and facilitate the group.
- 4.2 The work will be done over the next 2/3 months using the detailed template at Appendix 1 which has been agreed with the Advisory Group. Recommendations will then be considered by the Advisory Group before findings are presented to the GPhC and PSNI Councils.



## **5. Summary**

- 5.1 The meetings, and work by the GPhC in between, has ensured that the key stakeholders are abreast of the purpose of the group and have been able to shape the direction of the work for the task and finish group.
- 5.2 Having taken the necessary time to ensure stakeholders are agreed on the key areas of work and how it will be taken forward, we want to ensure the momentum is maintained through the work of the task and finish group. We are also conscious of the need for and benefit of quick wins where appropriate. This is important both in demonstrating the value of the group's work and because the pace of change and risks to patient safety means some actions may well be necessary in advance of all relevant analysis having been completed. Actions in relation to online pharmacies may well be one example, for instance.
- 5.3 We also need to continue emphasising the potential assurance role of different organisations – employers, education providers, commissioners of services, professional bodies - in the post-registration arena, to give patients and the public assurance that pharmacy services, delivered by pharmacists and pharmacy technicians are safe and effective.

## **6. Equality and diversity implications**

- 6.1 There are no specific equality and diversity issues raised at this stage. Equality impact assessments will need to be carried out to accompany any specific regulatory proposals, following the work of the task and finish group.

## **7. Communications**

- 7.1 Regular communications following the meetings of that group will be important to ensure the public, registrants and stakeholders are aware of the ongoing work and key decisions. We will also highlight this on our website.

## **8. Resource implications**

- 8.1 The work is currently being managed within existing resources. We will be considering whether any additional resources are required as part of the planning and budget for 2023/24. In line with the principles of right-touch regulation, we need to ensure that any regulatory interventions are proportionate, and their impact properly assessed.

## **9. Risk implications**

- 9.1 This work is specifically designed to address the potential for risks to patient safety arising from the pace of change and rapidly developing practice in pharmacy. Leading a new group to focus on post-registration assurance, including education and training, provides a basis for identifying the precise additional assurance mechanisms and appropriate responsibilities of different organisations.
- 9.2 While there is an important issue of pace here, there is also a risk of leaping to the wrong solutions to address particular patient safety issues. The uncertainty in many stakeholder responses supports the need to articulate the specific benefits and need for regulatory and other interventions if we are to provide the necessary public assurance.

## **10. Monitoring and review**

- 10.1 We will report regularly to Council, in a similar way to the updates provided from the work on initial education and training. The new stakeholder group will need to ensure that monitoring and review form a regular part of its work.

## **11. Recommendations**

The council is asked to note this information.

Mark Voce, Director for Education and Standards  
Laura Fulton, Director for Scotland

General Pharmaceutical Council

31/10/2022

## APPENDIX 1

### Taking the work forward – how the task and finish group should approach the work. Phase 1: education and training

What post-registration education and training exists currently for pharmacists and pharmacy technicians?	Are there gaps in the current assurance which affect patient safety?	Is any further evidence or intelligence needed to identify gaps	How could assurance of post-registration education and training be strengthened to address any gaps which affect patient safety?	How proportionate is/are your proposed solution(s)?	What would be the timescale for implementation of the solutions?
<p><i>Consider:</i></p> <ul style="list-style-type: none"><li>- the respective landscape for both professions in each of the four UK countries</li><li>- What is currently mandated for regulatory, professional or employment reasons</li><li>- how is it currently quality assured and by which organisation(s)</li><li>- Whether there is variation across different pharmacy sectors or settings?</li></ul>	<p><i>Consider:</i></p> <p>What the specific gaps are and what evidence supports the risk to patient safety?</p>	<p><i>Consider:</i></p> <p>Evidence of the numbers currently receiving education and training in the areas you have identified</p>	<p><i>Consider:</i></p> <ul style="list-style-type: none"><li>- Whether additional quality assurance mechanisms are required</li><li>- Whether additional training programmes or practice frameworks need to be developed, including sector or profession-specific</li><li>- The specific way any proposed measures improve patient safety</li></ul>	<p><i>Consider:</i></p> <ul style="list-style-type: none"><li>- the resources required to deliver changes and the organisation(s) responsible for implementation</li><li>- the scale of the benefits for patient safety alongside the impact on the workforce,</li></ul>	<p><i>Consider the work required by each applicable organisation/group, taking account of the scale of the change, operational and IT requirements and communications to patients and the public; and the professions</i></p>

# Board Assurance Report (interim format)

Year 2022/2023, Quarter 2

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## Section A: Chief Executive's report

- A.1 The purpose of this report is to provide Council with a high-level overview on four areas of the organisation's performance in Quarter 2 (July-September) 2022/23. This includes a summary of progress against the strategic plan 2020-25 (year 3) and supporting annual plan 2022/23, strategic and organisational risk, as well as operational and financial performance.
- A2. As our work around developing a board assurance framework continues, this report (in an interim format) will focus on escalating to Council areas of the organisation's performance for attention and assurance. More detailed reporting has been provided to the Senior Leadership Group (SLG) operating as a Performance and Delivery (P&D) Board, as part of this. In addition, the report supplements ongoing scrutiny of performance provided by some of our non-statutory committees, including audit and risk committee, workforce committee, finance and planning committee, and the quality and performance assurance committee.
- A.3 Sections B to D of this report set out key performance indicators and summaries for Council's attention in Q2 (July-September) 2022/23.

## Section B: Strategic Plan and Annual Plan summary report

- B.1 A high level summary of the progress of work planned this quarter under each of the strategic plan aims is set out below in Table 1. This quarter includes reporting on direction of travel (DoT):

**Table 1: Annual plan progress quarter 1 summary<sup>1</sup>**

	Q1	Q2	DoT	Q3	Q4
<b>Strategic aim 1</b>	G	G	→		
<b>Strategic aim 2</b>	R	R	→		
<b>Strategic aim 3</b>	G	G	→		
<b>Strategic aim 4</b>	A	A	→		
<b>Strategic aim 5</b>	A	G	↑		

G – on track/completed

A – some issues emerging, still achievable

R – significant issues

B – not scheduled to start

- B.2 Council should note that strategic aim 2 has been set a RAG status of Red. This relates particularly to the programme of work set out in our 2022/23 annual plan to 'improve the quality of reasoning

<sup>1</sup> The strategic aims are:

- 1 - Deliver an adaptable standards framework that meets public and professional needs that are changing quickly
- 2 - Deliver effective, consistent and fair regulation
- 3 - Drive improvements in pharmacy care by modernising how we regulate education and training
- 4 - Shift the balance towards more anticipatory, proportionate and tailored approaches to regulating pharmacy
- 5 - Enhance our capabilities and infrastructure to deliver our vision

in decisions and timeliness in fitness to practise’. The work on quality of reasoning in decisions is on track (‘green’) and making good progress. However, whilst work on timeliness is also making good progress, our existing caseload, size, age and complexity means that we will be unable to see the expected improvements in timeliness until 2023/24.

B.3 Further information on fitness to practise performance is provided in Section D of this report and Appendix F.1.

## Section C. Strategic risks and strategically significant operational risks summary report

- C.1 Changes within our strategic and operational risk registers during quarter 2 remain minimal. The main change to bring to Council’s attention is in relation to strategic risk 3 ‘inadequate education and training standards, and quality assurance activity’. This risk was previously flagged but has been downgraded following Council feedback and completion of several key planned actions.
- C.2 A verbal update on the November registration assessment will be provided at the November Council meeting as part of this performance report.

## Section D. Key performance summary report

- D.1 Overall, performance this quarter has improved. Five out of the seven service areas met their performance standards. One area (HR) fell short of one performance measure (absence) but still remained within tolerances, and one area (FtP) has fallen short of five out six re-based performance standards.
- D.2 A summary of performance across the seven service areas is shown in table 1 below:

Table 2: Service performance summary quarter 2

<div><div>G</div><div>→</div></div> <div>Customer Contact Centre</div>	<div><div>G</div><div>→</div></div> <div>Registration</div>	<div><div>R</div><div>→</div></div> <div>Fitness to Practise</div>
<div><div>G</div><div>↑</div></div> <div>Inspection</div>	<div><div>G</div><div>→</div></div> <div>Corporate Complaints</div>	<div><div>G</div><div>↑</div></div> <div>Information Governance</div>
<div><div>A</div><div>→</div></div> <div>Human Resources</div>		

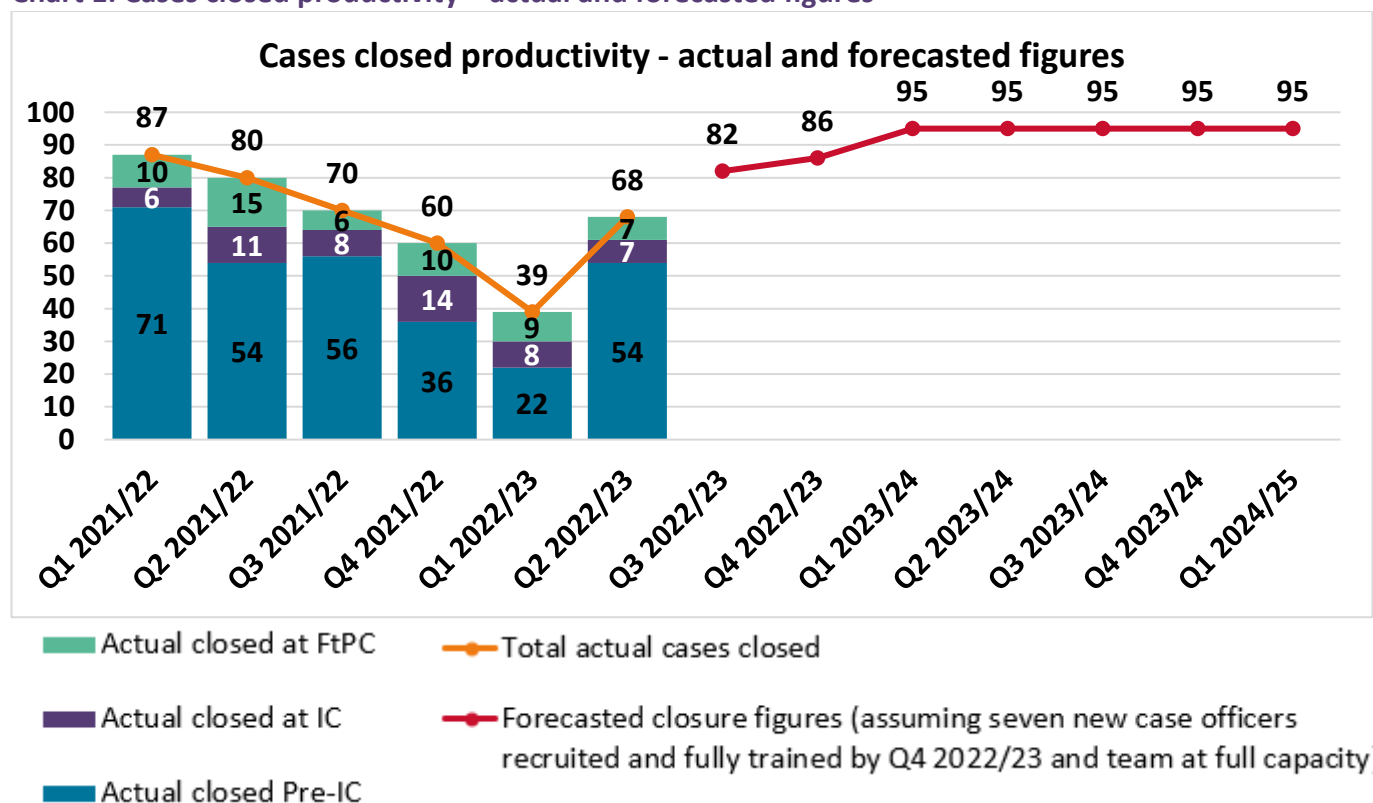
- D.3 In relation to fitness to practise, Appendix F1 provides a fuller update on the individual performance standards. These were adjusted in Q1 to provide a more realistic baseline using the averages achieved in 2021/22, except for the last measure on interim orders which we have retained. More work is being done to develop the staged improvement targets.
- D.4 Despite the overall red rag status this quarter there has been some encouraging improvements, resulting in a positive direction of travel with four out of the six measures improved. Council is asked to note the following:

- Productivity has increased significantly from the previous quarter, resulting in:
  - A significant increase overall in the number of cases closed within the various stages of the FTP process from the previous quarter at 68 (from 39)
  - The highest numbers of concerns having been triaged at 965
  - A very high number of interim orders being put in place in a quarter at 12
  - Over double the number of cases having been closed pre-IC this quarter than the last, at 52
- Whilst timeliness overall continues to fall short of performance standards, 71% of cases closed this quarter at FtP did so within 104 weeks (24 months), positively exceeding the re-based standard.

D.5 The improvements in productivity should be seen against a backdrop of having received the highest number of new concerns received at 1,118. In terms of scale, this represents a 30% increase from the previous quarter, which did have an impact on the timeliness at triage. Our data shows an increase this quarter in concerns about customer service and pharmacy premises. These concerns tend to be about delays in medicines being dispensed, lack of stock and unanticipated pharmacy closures and could reflect the significant pressures being faced by community pharmacy. We haven't seen a proportionate increase in concerns referred for investigation.

D.5 Chart 1 below illustrates the trend in actual cases closed (referred to above) by quarters against forecasted figures using projections with assumptions on recruitment, training and having a full headcount in place from Q1 2022/23.

**Chart 1: Cases closed productivity – actual and forecasted figures**

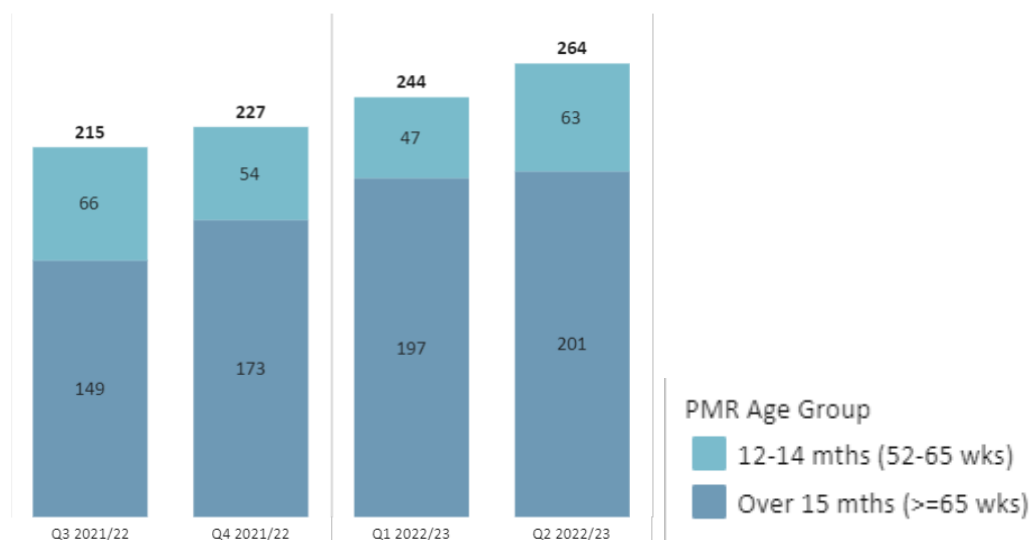




D.6 Although there was an encouraging increase in the numbers of cases closed, the number of open cases at the investigation stage continues to increase. The number of cases older than 12 months increased to 264 in Q1 from 244 in Q2, as seen in the Chart 3 below.

**Chart 3: Numbers of open cases over the age of 12 months at the investigation stage**

Open caseload by age group #



## Section E. Financial performance summary report

E.1 In summary, the GPhC are in a good financial position with our financial forecast still in line with previous projections. There are no issues requiring escalation to Council this quarter.

E.2 The table below summarises the revised forecast for the 2022/23 financial year following on from the reforecast exercise that took place at the end of quarter two.

**Table 3 - Finance overview**

	Budget	Fcst 1	Fcst 2	Fcst 1 vs Fcst 2 variance	
	£'000	£'000	£'000	£'000	%
Total Income	26,494	26,519	26,580	61	0.2%
Total Expenditure	27,217	27,101	26,864	237	0.9%
Total Interest & tax	184	245	320	75	30.6%
<b>Net Operating Surplus/(deficit) After</b>	<b>(539)</b>	<b>(337)</b>	<b>35</b>	<b>372</b>	
Changes in market value of investments	280	(871)	(1,803)	(932)	
<b>Surplus/deficit for the period</b>	<b>(259)</b>	<b>(1,208)</b>	<b>(1,768)</b>	<b>(559)</b>	

E.3 Finance and Planning Committee continue to monitor ongoing financial performance in more detail.

# Quarter 2, Performance Monitoring Report 2022/23

## Key

**Table 1: Red-Amber-Green (RAG) rating key**

Display	Description	Meaning
<b>G</b>	Green	Performance judged to be meeting or exceeding performance standard(s)
<b>A</b>	Amber	Performance judged to be within performance tolerance(s) (an acceptable level of normal variation expected)
<b>R</b>	Red	Performance judged to have fallen short of performance standard(s) and outside of tolerance(s)

**Table 2: Direction of travel (DOT) indicator**

Indicator	Description	Meaning
↑	Improving DOT	Performance has improved from what it was in the previous quarter
→	Staying the same	Performance has largely stayed the same as it was in the previous quarter
↓	Declining DOT	Performance has got worse than it was in the previous quarter

*\*Performance is reported to 1 decimal point for individual performance standards and is rounded up or down accordingly for the respective overall RAG rating for each service area*

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# Fitness to practise

**Table 1: Overall performance this quarter**

Quarter	RAG	DOT
Q2	R	→

## Performance summary

Performance in FtP during Q2 has remained red overall, with one performance measure meeting the re-based target, and improvements in increased productivity and timeliness in four of the six measures. Q2 saw the highest number of concerns ever received, the highest number of concerns triaged in a quarter and the highest number of interim orders applied for since 2016. Despite this, the team have continued to work hard at progressing cases through the FtP process at all stages.

We received an extremely high number of new concerns during Q2, 1,118 in total, our highest number ever received. This was following our highest ever number in the past year during Q1 (854). This was also during a period when the Initial Assessment Team were not at full capacity due to annual leave and sickness absence, with three members of staff new to the Assessment Officer role in Q1. Despite this, the team triaged 965 new concerns, our highest number ever. Timeliness was impacted by the exceptionally high volumes and the percentage of concerns triaged within 5 days dropped to 32%. The average 'time to triage' across the quarter has increased from 8.7 days in Q1 to 11.4 days in this quarter, which is expected given the volumes.

The number of investigations closed pre-IC increased during Q2 to 52. This is more than double investigation closures during Q1 (20). At the end of Q1 we welcomed new starters and saw the results of changes we had made earlier in the year starting to embed. Although the performance against the KPI for pre-IC investigations was low (23%) this represents our continued focus on older cases. During Q3 we will be welcoming 8 new Case Officers who, once settled into the role, will boost quarterly productivity.

The number of cases referred to the IC during Q2 remained relatively stable at 15. Although only three cases were referred within the 12-month KPI, this again reflects a continued effort to focus on progressing older cases which have already exceeded the KPI.

We closed or referred 18 cases at the IC this quarter, the same as Q1. As previously stated, following the peak in Q4, we anticipate the number of cases closed or referred by the IC to stabilise going forward and we expect to see continued low compliance with the KPI as we work through some of our oldest and most complex cases. The number of cases closed at the Fitness to Practise Committee stage remains stable at seven cases. Five of these cases concluded within 24 months, meeting the re-based KPI.

The Fitness to Practise Committee imposed 12 interim orders during Q2, a record number for the year and the highest recorded since 2016. As explained in the Q1 performance report, this was partly due to our drive to progress online prescribing cases in Q1 and Q2. These cases were risk assessed, with very large volumes of material being reviewed, additional external counsel instructed, special panel listings to manage the volumes of work and various applications for adjournments and delays. Higher than usual numbers of cases were placed before the Fitness to Practise Committee for interim orders. Despite this, the median time taken to impose an interim order improved from 3.6 weeks to 3.1 weeks.

**Table 2: Fitness to practise quarterly performance**

Performance measure	Re-based Performance standard (Original standard) <sup>1</sup>	Q2	RAG	DOT	Q1	Q4	Q3
Concerns triaged within 5 working days	59% (80%)	<b>32%</b> (305/965)	<b>R</b>	↓	42% (339/814)	53% (414/786)	54% (439/812)
Cases closed pre-IC within 44 weeks (10 months)	39% (80%)	<b>23%</b> (12/52)	<b>R</b>	↑	0% (0/22)	28% (10/36)	33% (18/55)
Cases referred to the IC within 52 weeks (12 months)	26% (80%)	<b>20%</b> (3/15)	<b>R</b>	↑	11% (2/18)	6% (1/18)	22% (8/36)
Cases closed or referred at IC which reach IC within 60 weeks (14 months)	27% (80%)	<b>0%</b> (0/18)	<b>R</b>	↓	6% (1/18)	15% (4/27)	41% (7/17)
Cases closed at FtPC within 104 weeks (24 months)	29% (85%)	<b>71%</b> (5/7)	<b>G</b>	↑	22% (2/9)	30% (3/10)	17% (1/6)
Median time (weeks) from receipt of information suggesting an immediate risk to interim order (IO) being imposed	(3 weeks)	<b>3.1 wks</b> (12 IOs)	<b>A</b>	↑	3.6 wks (7 IOs)	3.4 wks (3 IOs)	2.3 wks (6 IOs)

<sup>1</sup> The re-based figures show the average performance for 2021/22 for comparison against to provide a more realistic baseline for timeliness to track improvement over time. The figures in brackets are the previous performance standard targets where the last performance measure on the median time for interim orders (IO) being imposed has not been rebased. We are working to define agreed tolerances where the performance for the IO performance measure has been rated as Amber as a judgement call.

# Engagement and communications report

## Meeting paper for Council meeting on 10 November 2022

### Public business

#### Purpose

To update the Council on engagement and communications with stakeholders through a quarterly report.

#### Recommendations

The Council is asked to note this paper.

#### 1. Introduction

- 1.1 This report outlines key communications and engagement activities since June 2022 and highlights upcoming events and activities.

#### 2. Duty of candour: roundtable meeting and new resources

- 2.1 On Monday 13 June, Chair of the GPhC, Gisela Abbam, hosted a virtual roundtable meeting on the duty of candour, attended by the Chief Pharmaceutical Officers and organisations representing pharmacy professionals, employers and students, patients and the public and other regulators.
- 2.2 At the roundtable, we sought feedback on new resources we had developed for pharmacists and pharmacy technicians to help them fulfil the duty of candour - the professional responsibility to be open and honest with patients when something goes wrong.
- 2.3 Participants at the roundtable also discussed further actions that we can all take to make sure everyone working in pharmacy understands their responsibilities to be open and honest when things go wrong, and to improve patient safety.
- 2.4 On 22 June, we published the new resources **Keeping patients safe – being open and honest** and **Pharmacy team toolkit – learning from incidents**. These resources bring together relevant existing policy, standards, and previous statements on the professional obligations of pharmacists and pharmacy technicians, with respect to candour.
- 2.5 We promoted these new resources to pharmacy professionals through direct emails, articles in the pharmacy trade media, our e-newsletter Regulate and social media activity.

### **3. Communications about the registration assessment**

- 3.1 A key priority during this period has been to issue clear and helpful communications to candidates and stakeholders to explain the actions we were taking in response to the problems and issues experienced by candidates in the June registration assessment.
- 3.2 Following the June assessment, we quickly issued updates via social media and email to candidates and stakeholders about what had happened and our initial response, and to ask candidates to tell us about their experiences. We also continued to issue regular updates as key decisions were made by the Council, including in relation to provisional registration and the options for unsuccessful candidates to appeal.
- 3.3 We also coordinated direct engagement with candidates and the organisations supporting them. This included organising listening events with candidates, to give them the opportunity to share their experiences and feedback about the June assessment directly to GPhC staff and Council members. The listening events also gave us the opportunity to build understanding among candidates about the actions we are taking in response to the issues they have raised, and explain to candidates who experienced major disruption their options if they were unsuccessful.
- 3.4 The main online listening event on 26 July was attended by 575 people and the recordings were viewed 641 times. We also held several smaller listening events and meetings, including meeting a delegation of candidates affected by the issues at test centres.
- 3.5 On 29 July, we announced the results of the June 2022 registration assessment, with 80% of candidates successfully passing the assessment.

#### **November sitting**

- 3.6 Another key priority has been to engage and communicate with candidates and stakeholders about the plans for the November registration assessment.
- 3.7 We have engaged directly with organisations including the British Pharmaceutical Students Association (BPSA) and Pharmacists Defence Association (PDA) to discuss our plans for the November sitting, and how the measures we are putting in place have been informed by the feedback we received about the June sitting.
- 3.8 Candidates for the November sitting have received regular updates to inform them about the arrangements for sitting the assessment. These updates have included details about the actions we are taking to reduce the risks of the issues experienced by some candidates in June happening in November.
- 3.9 In early October, we held a webinar for the candidates sitting in November to explain the measures we were putting in place for the November assessment, to provide reassurance to the candidates. We also discussed how to prepare for the day and the support available for candidates' well-being, and provided a demonstration on how to use the assessment software in the most effective and efficient way to display and answer the questions.
- 3.10 The webinar was attended by 430 people and the recordings were viewed 384 times

### **4. Pharmacy Orders**

- 4.1 Two pharmacy-related orders [the Pharmacy (Preparation and Dispensing Errors – Hospitals and Other Pharmacy Services) Order 2022 and the Pharmacy (Responsible Pharmacists,

Superintendent Pharmacists etc.) Order 2022] were published on 24 October 2022 after being approved by the Privy Council. The orders are both expected to be commenced and come into force on 1 December 2022.

- 4.2 We issued a **statement from Duncan Rudkin, our Chief Executive**, which welcomed the publication of the orders and explained the key changes that these orders would introduce.
- 4.3 The statement explained that once the orders are commenced, we will begin engaging extensively with patients and the public, health professionals, the NHS and the wider health sector, to discuss the requirements and expectations around the roles of Responsible Pharmacists, Superintendent Pharmacists and Chief Pharmacists.
- 4.4 This statement was shared with the pharmacy trade media and stakeholders, as well as being published on our website, and led to significant media coverage.
- 4.5 Further detailed communications about the next steps, including how the rules and standards will be developed, will be shared with all key audiences after the orders are commenced.

## 5. Risks relating to online pharmacy services

- 5.1 In August, we **wrote to all pharmacists and owners of pharmacies with the GPhC's voluntary internet pharmacy logo**, after identifying further patient safety concerns affecting the online sector.
- 5.2 These communications set out the key issues and themes we were identifying through our Fitness to Practise investigations and inspections, and the actions we are taking in response. They also set out what pharmacists and owners must do if working for an online service.
- 5.3 Our communications were covered by the Daily Telegraph, the Daily Mail and across the pharmacy trade media, and were also shared by stakeholders through their networks.
- 5.4 In October, we issued a **special edition of Regulate** which focused on online pharmacies. This special edition included a blog from our Chair, an in-depth article on the issues we were identifying in online pharmacy services, and an article identifying examples of good practice in an online pharmacy.

## 6. Announcement of the extension of the temporary register

- 6.1 The Secretary of State for Health and Social Care has asked the General Pharmaceutical Council and the other relevant health professional regulators to keep our temporary registers for a further two years.
- 6.2 This decision was announced by the UK Government in its **'plan for patients'** in England, published on 26 September. This decision was made to enable health professionals on the temporary registers to continue to support the health and social care system.
- 6.3 The UK Government had previously announced that the temporary registers established by the health professional regulators were expected to close on 30 September 2022.
- 6.4 Following the announcement, we wrote to all pharmacists and pharmacy technicians on our temporary register to let them know that the temporary register will now remain open for the next two years. We also **shared this update with key stakeholders**, including

organisations representing employers, and asked them to share this news via their channels.

## **7. New guidance for entry to independent prescribing courses**

- 7.1 We published new guidance for pharmacist independent prescribing course providers and applicants to these courses in early October. This new guidance supports changes to the entry requirements for independent prescribing training, which enables pharmacists to begin a course when they have the relevant experience and awareness.
- 7.2 We shared the new guidance widely with organisations and individuals with an interest in pharmacist independent prescribing, and **explained through our communications** the next steps and what this meant for pharmacists who may be considering applying for an independent prescribing course.

## **8. Racism in pharmacy roundtable**

- 8.1 On 1 November 2022, we held an online roundtable meeting to focus on a specific equalities issue - racism in pharmacy. The aim of this event was to discuss with stakeholders from across health and pharmacy how racism manifests and impacts on pharmacy and other health professionals, and how this can have a resulting impact on patient care, and to identify any further actions that we can take, to ensure a co-ordinated approach.
- 8.2 Speakers included Marie Gabriel, Chair of the NHS Race and Health Observatory; Elsy Campos-Gomez, Chair of the UK Black Pharmacist Association; and Dr Mahendra Patel, Pharmacy, and Inclusion and Diversity Lead, for the PANORAMIC and PRINCIPLE Trials run by the University of Oxford.
- 8.3 Following the event, we are planning further communications to share the key themes and actions discussed at the roundtable.

## **9. Further communications on sodium valproate**

- 9.1 We have **recently written to all pharmacy professionals and owners** to remind them of the requirements to follow the Pregnancy Prevention Programme whenever dispensing sodium valproate to women who may be of childbearing age.
- 9.2 This followed recent reports from INFACT, which represents women and families affected by sodium valproate, of at least two examples where valproate had been dispensed to women in a white box with no safety warnings or Patient Information Leaflet. Our inspectors have followed up with these pharmacies and their Superintendents to make sure they understand what went wrong, that procedures are reviewed and that the whole pharmacy team is made aware of what they must do to dispense valproate safely.
- 9.3 Our communications to pharmacy professionals were referenced in a Sunday Times article in October about ongoing concerns relating to the prescribing and supply of sodium valproate.

## **10. Statements on key issues within pharmacy and regulation**

- 10.1 During this period, we published statements on some key issues within pharmacy and our role and position in relation to those issues.



- 10.2 In July, we published a statement on **potential industrial action by pharmacy professionals**. This statement recognised that pharmacy professionals do have the right to support and take part in lawful industrial action. It also emphasised that pharmacy professionals must meet our standards at all times.
- 10.3 In September, we published a statement on **temporary closures of pharmacies**. The statement sets out how the issue of pharmacy closures relates to our role and remit as the independent regulator as well as the wider context of pharmacy service delivery.

## **11. Update on the website project**

- 11.1 We are currently working to develop a new main corporate website for the GPhC, to replace the current website, which will go out of support in November 2023.
- 11.2 The development of the new website has taken significantly longer than expected due to a number of complex factors. These factors have included:
- (a) the availability of our web agency to undertake further development work, as the initial agreed time for development was not sufficient to complete the scale of the work
  - (b) quality issues on the outputs delivered by the agency which have meant the need to rework and redevelop key pieces of functionality in order to make sure the new website meets all of our detailed requirements and provides a good experience to external and internal users.
  - (c) resourcing capacity across GPhC teams, particularly the Comms team, the IT team and the core project team.
- 11.3 We have now completed around 95% of the tasks relating to build and development of the website and successfully completed quality-assurance of these tasks. Further development is planned in November, December and January to complete the remaining tasks; which will also have to be quality assured prior to being released for testing.
- 11.4 We have begun detailed user acceptance testing of the many different features and sections of the new website with internal users. We expect to undertake user acceptance testing with external users and an external audit to check the new website meets accessibility requirements early next year. We will then move to final go-live preparations.
- 11.5 The new website is now expected to launch in the first part of 2023. This timeline and the internal and external resources required to complete the project remain under close review.

## **12. Recent events and meetings**

- 12.1 Please see appendix 1 for a list of key events and meetings that have taken place since June 2022.
- 12.2 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 ensure they have the most up-to-date supporting material.

### 13. Upcoming events and activities

Please contact Laura Turton, Stakeholder Engagement Manager, at [laura.turton@pharmacyregulation.org](mailto:laura.turton@pharmacyregulation.org) if you would like to attend any of these events:

#### **National Pharmacy Association Forum Wales, 16/11/22**

Helen Boniface (Inspector) presentation on GPhC update. Event 10:00-13:00.

#### **Women in Leadership and Healthcare Webinar, 30/11/22**

Gisela Abbam (Chair) speaking at this event being hosted by the International Pharmaceutical Students' Federation. Event 19:00-20:00.

### Consultations

- 13.1 Please see appendix 2 for the grid of active and new external consultations to which we have considered responding.

### 14. Equality and diversity implications

- 14.1 During this period, we have continued to support the implementation of our strategy on delivering equality, improving diversity and fostering inclusion through our communications and engagement.
- 14.2 As well as supporting the racism in pharmacy roundtable, we have also supported our Chair and SLG members to speak at key external events relating to equality and diversity. This included Gisela speaking on a panel about race equity at work at an online event organised by the British Medical Journal to mark Black History Month. Gisela also spoke to GPhC colleagues at our staff Inclusion Network Black History Month event.
- 14.3 Another key priority over this period has been to raise awareness and understanding among our staff about our commitment in the strategy to listening to a diverse range of voices when developing policies, standards or guidance. We have done this through a new video produced with members of our patient panel, alongside a series of articles on Infopoint about our approach to patient and public engagement and how we are continuing to improve our approach in this area.
- 14.4 Our current priority is to develop a special edition of Regulate for December which will feature articles relating to equality and diversity, including about our new equality guidance for pharmacies, and new Pride in Practice resources to support LGBTQ+ inclusive healthcare.

### 15. Recommendations

The Council is asked to note this paper.

Rachael Gould, Head of Communications  
General Pharmaceutical Council

01 November 2022

## Appendix 1

### Events from 9 June to 9 Nov 2022

**GPhC Duty of candour roundtable, 13/06/22**

Roundtable discussion on key issues relating to the duty of candour

**Initial Education and Training of Pharmacists update webinar, 14/06/22**

Presentation and Q&A on reforms to Initial Education and Training of Pharmacists

**NHS Scotland Conference, 21/06/22 to 22/06/22**

GPhC exhibition stand

**Association of Independent Multiple Pharmacies members conference, 30/06/22**

Gisela Abbam (Chair) introductory presentation

**Community Pharmacy Hertfordshire AGM, 04/07/22**

GPhC exhibition stand

**Local Pharmaceutical Committee Strategic Monthly Meeting, 21/07/22**

Lindsay Woodford (Inspector) presentation on revalidation

**Well Pharmacy trainee pharmacist event, 26/07/22**

Akhtar Malik (Inspector) presentation on introduction to the GPhC

**Registration assessment online listening session, 26/07/22**

GPhC listening event

**Professional Standards Authority Report launch, 06/09/22**

Gisela Abbam (Chair) and Duncan Rudkin (Chief Executive) attended

**UK Commission on Pharmacy Professional Leadership - call for evidence webinar (Scotland)**

Gisela Abbam (Chair) presentation

**UK Commission on Pharmacy Professional Leadership - call for evidence webinar (England), 07/09/22**

Gisela Abbam (Chair) presentation

**Cambridgeshire LPC AGM, 07/09/22**

Susan Melvin (Inspector) presentation on update from the GPhC

**Southeast forum of Local Pharmaceutical Committees, 08/09/22**

David Clark (Inspector) presentation on update from the GPhC

**Pharmacy Education conference 2022: Initial Education and Training of Pharmacists in a Post-Pandemic World, 12/09/22**

Lisa Smith (Professional Assessment Manager) and Niall Stewart-Kelcher (Senior Registration Assessment Officer) poster and presentation

**Association of Pharmacy Technician UK Duty of Candour webinar, 22/09/22**

Duncan Rudkin (Chief Executive) presentation

**Kent Local Pharmaceutical Committee AGM, 28/09/22**

David Clark (Inspector) update on GPhC presentation

**NHS Education for Scotland trainee event, 28/09/22**

Alasdair Shearer (Inspector) presentation on introduction to the GPhC

**Independent Pharmacy Awards 2022, 30/09/22**

Gisela Abbam (Chair) attended

**Association of Police Controlled Drug Liaison Officers (APCDLO) conference, 30/09/22**

Chris Barnes (Inspector) presentation on GPhC update

**Parliamentary Session – Disability in Pharmacy 03/10/22**

Laura Fulton (Director for Scotland) presented

**GPhC and RPS Shared Patient Records Discussion, 05/10/22**

Round table discussion on the barriers and enablers to achieve a shared patient record

Laura Fulton (Director for Scotland) co-hosted

**Launch of The Economist Impact Global Health Inclusivity Index, 10/10/22**

Gisela Abbam (Chair) attended

**Scottish Government Professional Health and Social Care Regulatory Event, 24/10/22**

Duncan Rudkin, Mark Voce, Claire Bryce-Smith and Laura Fulton presented

**BMJ Race Equity at Work Panel Discussion, 27/10/22**

Gisela Abbam (Chair) participated in a panel discussion

**GPhC Racism in pharmacy roundtable, 01/11/22**

Roundtable discussion on impact of racism on pharmacy professionals and how this can have a resulting impact on patient care

**Association of Independent Multiple Pharmacies Annual Dinner & Awards, 04/11/22**

Gisela Abbam (Chair) attended

**Professional Standards Authority Safer Care for All conference, 09/11/22**

Gisela Abbam (Chair) participated in a keynote session and Duncan Rudkin (Chief Executive) attended.

## Meetings from 9 June 2022

Listed below is a non-exhaustive selection of significant meetings since the last engagement and communications report to Council.

Initials are as follows: Gisela Abbam (GA), Duncan Rudkin (DR), Carole Auchterlonie (CA), Claire Bryce-Smith (CBS), Laura Fulton (LF), Liam Anstey (LA), Mark Voce (MV)

### 1. Chair (Gisela Abbam):

- Meeting with Chief Executive of Pharmaceutical Services Negotiating Committee (with DR)

- Meeting with Chair and Chief Executive of Professional Standards Authority (with DR)
- Meeting with Chair of Care Quality Commission
- Meeting with Chair of General Optical Council
- Meeting with Chair of Pharmacists' Defence Association (with DR)
- Meeting with Chair of Royal College of General Practitioners (with DR)
- Meeting with Chief Executive of King's Fund (with DR)
- Meeting with Chief Executive of The Patients Association (with DR)
- Meeting with founder of Written Medicine (with DR)
- Meeting with Pharmacy Schools Council (with DR and MV)
- Meeting with President and Chief Executive of Pharmaceutical Society Northern Ireland (with DR)
- Meeting with President of Association of Pharmacy Technicians UK (with DR)
- Meeting with President of Law Society
- Meeting with President of UK Black Pharmacists Association (with DR)
- UK Commission into Pharmacy Professional Leadership (GA)
- UK Commission Pharmacy: Regulatory Support meeting (with DR)
- UK CPhO Commission on Pharmacy Professional Leadership: Leadership, Policy and Professionalism Working Group

## **2. Staff:**

- Advanced Pharmacist Practitioner Subgroup (LF)
- Chief Executive's Steering Group (DR)
- Chief Executives of Regulatory Bodies (DR)
- Chief Pharmaceutical Officer for Scotland (LF)
- Chiropractic, Optical, Pharmacy, Osteopathic and Dental regulatory bodies (CA)
- Clinical Academic Careers Short Life Working Group (MV)
- Community Pharmacy Incident Reporting Quarterly Meeting (LA)
- Consultant Pharmacist Group (LF)
- CPhO Fellows meeting (CBS)
- Cross Regulatory Forum Digital Apps (CBS)
- Cross-Border Regulatory Subgroup (CBS)
- Digital Clinical Excellence (DiCE) Forum (CBS)
- Foundation Training Year Working Group (LF)
- Health and Social Care Regulators Forum (DR)

- Health Education and Improvement Wales Pharmacy Advisory Board (LA)
- Health Education England and NHS England & NHS Improvement Pharmacy Meeting (MV)
- Health Education England and Regulators Roundtable (DR)
- Inclusive Pharmacy Practice Advisory Board (DR)
- Institute of Regulation Members Quarterly Event (DR)
- Leadership Learning in the Pre-Registration Healthcare Curriculum Joint Working Group (MV)
- Medicines and Healthcare products Regulatory Agency and Department of Health and Social Care roundtable (CBS)
- Meeting with Association of Independent Multiple Pharmacies (DR,CA)
- Meeting with Association of Pharmacy Technicians UK (LF)
- Meeting with Avicenna (CBS)
- Meeting with British Pharmaceutical Students Association (MV)
- Meeting with Cardiff University (LF)
- Meeting with Care Quality Commission (CBS)
- Meeting with Chief Pharmaceutical Officer for England (DR)
- Meeting with Chief Pharmaceutical Officer for Wales (LA)
- Meeting with Community Pharmacy Scotland (LF)
- Meeting with Community Pharmacy Wales (LA)
- Meeting with Company Chemists Association (DR, CBS)
- Meeting with Competitions and Markets Authority (DR, CBS, CA)
- Meeting with Controlled Drugs Accountable Officers Network (LF)
- Meeting with General Medical Council Scotland (LF)
- Meeting with General Optical Council (DR)
- Meeting with General Teaching Council for Scotland and Scottish Social Services Council (LF)
- Meeting with Health Education and Improvement Wales (LA)
- Meeting with Healthcare Improvement Scotland (LF)
- Meeting with Lloyds (DR, CBS, CA)
- Meeting with National Pharmacy Association (DR, CBS, MV)
- Meeting with NHS Education for Scotland (LF)
- Meeting with NHS England & NHS Improvement (CBS)
- Meeting with NHS Fife (LF)
- Meeting with NHS Golden Jubilee (LF)

- Meeting with NHS Greater Glasgow and Clyde (LF)
- Meeting with NHS Highland (LF)
- Meeting with NHS Lothian (LF)
- Meeting with NHS Scotland (LF)
- Meeting with NHS Tayside (LF)
- Meeting with Numark (CBS)
- Meeting with Nursing and Midwifery Council (LA)
- Meeting with Pharmaceutical Society of Northern Ireland (DR, MV)
- Meeting with Pharmacists' Defence Association (DR, CBS, CA)
- Meeting with Pharmacists' Defence Association (LA,LF)
- Meeting with Pharmacy Schools Council (MV)
- Meeting with Professional Standards Authority (CBS, CA)
- Meeting with regulators in Scotland (LF)
- Meeting with Royal Pharmaceutical Society (CBS)
- Meeting with University of Brighton (MV)
- Meeting with University of Central Lancashire (MV)
- Meeting with University of Strathclyde (LF)
- Meeting with University of Wolverhampton (MV)
- Meeting with Welsh Language Commissioner (LA)
- Meetings with Department of Health and Social Care (DR, CBS, CA)
- Ministerial Roundtable Webinar - Professional and Regulatory Flexibility (MV)
- MPharm/ACT group (LF)
- National Overprescribing Review Implementation Oversight Group (DR)
- National Pharmacy Workforce Forum (LF)
- NHS England and NHS Improvement Interim Cross Regulator Group (CBS)
- NHS England and NHS Improvement Pharmacy Integration Clinical Reference Group (CBS)
- NHS Scotland - Foundation Training Year Working Group (LF)
- NHS Scotland Achieving Excellence in Pharmaceutical Care Advisory Group meeting (LF)
- Optimising System Capacity, Blended Learning Ministerial Roundtable Webinars (MV)
- Pharmacist Initial Education & Training Strategic Group (LF)
- Pharmacist Post Registration Strategic Group (LF)
- Pharmacy Data Delivery Group (CBS, MV)
- Pharmacy Integration Clinical Reference Group (CBS)

- Pharmacy Technician Delivery Group (MV)
- Pharmacy Technicians Education & Training Strategic Group (LF)
- Pharmacy Workforce Steering Group (LA)
- Primary Care Stakeholder Forum (CBS)
- Regulators in Wales meeting (LA)
- Regulators Online Health Care Regulation Group (CBS)
- Royal Pharmaceutical Society Pharmacy Vision in England Advisory Group (DR)
- Royal Pharmaceutical Society Scotland (LF)
- Royal Pharmaceutical Society Wales (LA)
- Scottish Pharmacy Clinical Leadership Fellows alumni inaugural meeting (LF)
- Sharing Intelligence for Health & Care Group and Healthcare Professional Regulators Meeting (LF)
- Study of Career Pathways & Progression for Pharmacists and Pharmacy Technicians (LF)
- Transforming Careers - Consultant Pharmacist meeting (LF)
- UK Cross Border Regulatory Subgroup (CBS)
- Welsh NHS Confederation Health and Wellbeing Alliance (LA)
- Workforce Issues Steering group (LA)



## Appendix 2

### Active and new consultations

The table below lists all the consultations we have considered and provided responses to. Consultations we have responded to are listed first; those we have considered but not responded to appear next on the list.

Please note that we do not normally respond to consultations from other independent statutory health professional regulators. These are reviewed, shared and considered, but usually it is not appropriate or necessary for the GPhC to respond.

**Table 1: Active and new consultations**

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>Hub and spoke dispensing</u></b>	<b>DHSC</b>	Seeking views on proposals to enable all community pharmacies to access 'hub and spoke' dispensing.	08/06/2022	Responded to	Formal written response	AA (Policy & Standards)	We are responding to this consultation as it is relevant to our work. We have limited our response to those proposals that, if implemented, would have an impact on our role as the independent regulator of pharmacy professionals and registered pharmacies.	<a href="https://www.pharmacyregulation.org/sites/default/files/document/gphc-response-to-dhsc-hub-and-spoke-consultation-june-2022.pdf">https://www.pharmacyregulation.org/sites/default/files/document/gphc-response-to-dhsc-hub-and-spoke-consultation-june-2022.pdf</a>
<b><u>The Duty of Candour</u></b>	<b>Welsh Government</b>	Consultation on the Statutory Guidance and Regulations required to implement the Duty of Candour.	13/12/2022	Reviewed and being responded to	Online response form	LA (Director for Wales)	We are in the process of responding to this consultation. Encouraging and supporting the professionalism of the	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
							pharmacy team and promoting a culture of openness and candour, which focuses on what matters to patients, is fundamental to the GPhC's regulatory approach and strategy.	
<b><u>Consultation on how MHRA communicate with healthcare professionals to improve medicines and medical devices' safety</u></b>	<b>MHRA</b>	Consultation on how MHRA communicates with healthcare professionals to improve medicines and medical devices' safety.	18/01/2023	Being reviewed	Online response form	AA (Policy & Standards)	We are in the process of reviewing this consultation to determine whether a response is required and what this will entail.	
<b><u>Mental health and wellbeing plan: discussion paper and call for evidence</u></b>	<b>DHSC</b>	The government has committed to develop a new cross-government, 10-year plan for mental health and wellbeing for England to support this objective.	07/07/2022	Reviewed but not responding	No response	AA (Policy & Standards)	We submitted our response to the DHSC consultation on hub and spoke, and received an invitation to provide feedback on their National Suicide Prevention Plan work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
							However, on closer inspection it appears to be outside our remit.	
<b><u>A new mental health and wellbeing strategy</u></b>	<b>Scottish Government</b>	Seeking views on what a new Mental Health and Wellbeing Strategy for Scotland should look like.	09/09/2022	Reviewed but not responding	No response	LF (Director for Scotland)	We have considered this consultation, but felt that it does not directly relate to our key role and functions, nor does it directly impact on our registrants.	
<b><u>NHS Pension Scheme: proposed amendments to continue the suspension of restrictions on return to work</u></b>	<b>NHS England</b>	This consultation proposes to continue the 'retire and return' easements until 31 March 2023 via amendments to NHS Pension Scheme regulations.	12/09/2022	Reviewed but not responding	No response	AA (Policy and Standards)	We have reviewed this consultation with interest. Although the topic is relevant to the GPhC particularly in relation to our temporary register we have decided not to respond on this occasion as it falls outside our remit.	
<b><u>Transforming the future of pharmacy practice in England</u></b>	<b>Royal Pharmaceutical Society RPS</b>	This consultation outlines six themes identified as core to a professional vision for pharmacy practice. The themes reflect aspirations of The	30/09/2022	Reviewed but not responding	No response	AA (Policy & Standards)	We have reviewed this consultation with interest. Although the topic is relevant to the GPhC as an organisation, we are not amongst the target	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<a href="#"><u>(rpharms.com)</u></a>		Long-Term Plan and recent Fuller Stocktake as well as the aspirations of the pharmacy profession.					audiences for this consultation. We will monitor any subsequent developments closely.	
<a href="#"><u>Clinical genomics service specification consultation - NHS England - Citizen Space</u></a>	NHS England	Seeking views on proposed changes to the Clinical genomic service specification. The Service Specification outlines standards for clinical genomic services in England.	30/09/2022	Reviewed but not responding	No response	AA (Policy & Standards)	We are not responding to this consultation as it falls outside our scope and remit. However, we will continue to monitor any relevant developments.	
<a href="#"><u>Proposed changes to the assessment of mathematics, physics and combined science GCSEs in 2023</u></a>	Ofqual	Seeking views on proposed adaptations to the assessment of GCSEs in mathematics, physics and combined science for students in England taking exams in 2023.	20/10/2022	Reviewed but not responding	No response	DD (Education)	We are not responding to this consultation as it is unlikely the proposals will have an impact on our work or that of our registrants.	
<a href="#"><u>Developing a national framework</u></a>	Welsh Government	Consulting on a suitable model for social prescribing across Wales.	20/10/2022	Reviewed but not responding	No response	LA (Director for Wales)	We are not responding to this inquiry. However, we are following	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>for social prescribing</u></b>							developments, as there might be relevant implications for our work.	
<b><u>Proposed changes to legislation on social care and continuing health care</u></b>	Welsh Government	Seeking views on changes to primary legislation in relation to health and social care.	07/11/2022	Reviewed but not responding	No response	LA (Director for Wales)	We are not responding to this inquiry. However, we are following developments, as there might be relevant implications for our work.	
<b><u>NHS England Consultation on the revised NHS enforcement guidance</u></b>	NHS England	Consultation on the revised NHS enforcement guidance.	09/12/2022	Reviewed but not responding	No response	n/a	We are not responding to this consultation as it is outside our remit.	
<b><u>ICO consultation on the draft employment practices: monitoring at work guidance and draft impact assessment</u></b>	Information Commissioner's Office (ICO)	The Information Commissioner's Office (ICO) is producing and consulting on topic-specific guidance on employment practices and data protection.	11/01/2023	Reviewed but not responding	No response	CG (Governance)	We have reviewed the draft guidance, but we have felt that we could not make any substantive contribution to the issues raised in the consultation, on this occasion.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>Proposed changes to Good medical practice</u></b>	<b>GMC</b>	Seeking views on a draft, updated version of Good medical practice.	20/07/2022	Reviewed but not responding	No response	AA (Policy & Standards)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<b><u>NMC launches consultation on English language requirements</u></b>	<b>NMC</b>	Seeking views on two areas related to English language requirements. First, the NMC's approach to testing. Secondly, whether the NMC should consider accepting other evidence of English language competence. This might include employer references, evidence of unregulated practice in UK health and care settings, or postgraduate qualifications that people have studied in English.	12/08/2022	Reviewed but not responding	No response	DD (Education)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
<b><u>Our strategic plan for the next three years: your views</u></b>	GDC	Seeking views on the GDC's proposed strategy which focuses on ways both to prevent patient harm and to be proportionate when handling the concerns we receive, progressing our ambition to shift the balance from enforcement to prevention.	06/09/2022	Reviewed but not responding	No response	LMc (Chief of Staff)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<b><u>Consultation on draft Practice Note: Questioning Witnesses</u></b>	GOsC	Seeking views on the revised version of the GOsC's practice note for questioning witnesses to ensure we meet the needs of those involved in our fitness to practise hearings.	31/10/2022	Reviewed but not responding	No response	JM (FtP)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	
<b><u>Consultation on Pharmacy Staffing Levels Guidance</u></b>	PSNI	Seeking views on proposed Guidance on Pharmacy Staffing Levels within registered premises. This follows proposals made to the PSNI	09/12/2022	Reviewed but not responding	No response	AA (Policy & Standards)	We are not responding to this consultation as it is outside our jurisdiction. However, we will continue to follow developments closely.	

Consultation title	Organisation	Description	Deadline	Response status	Type of response	GPhC lead	Reasoning	Link to GPhC response
		Council in September 2022 based on engagement with stakeholders.						
<b><u>A new EDI Standard for Accredited Registers</u></b>	<b>Professional Standards Authority (PSA)</b>	Consultation on a new Equality, Diversity and Inclusion Standard for Accredited Registers.	17/01/2023	Reviewed but not responding	No response	AS (EDI)	We are not responding to this consultation as it relates to the PSA accredited registers work which the GPhC is not involved in.	
<b><u>The Safe Practitioner: A framework of behaviours and outcomes for dental professional education</u></b>	<b>GDC</b>	Seeking views to ensure people joining the GDC register continue to have the right skills, knowledge and behaviours.	10/01/2023	Reviewed but not responding	No response	DD (Education)	We are not responding to this consultation. However, we are following developments, as there might be relevant implications for our work.	



# Council re-appointments for April 2023

## Meeting paper for Council on 10 November 2022

Public

### Purpose

To agree the process for filling five vacancies on Council with effect from 1 April 2023

### Recommendations

The Council is asked to agree that the re-appointments process may be used to fill the vacancies which will arise on Council when five members complete a term of office on 31 March 2023, in line with the previous decisions taken on staggering

### Introduction

- 1.1 The policy on the appointment and re-appointment of Council members (including the Chair) was reviewed and approved by Council in September 2020. It sets out the guiding principles for appointments and re-appointments and the approaches which will be followed. The policy is attached at **Appendix 1** for reference and the guidance on re-appointments can be found in section 10. The policy has been checked against the Professional Standards Authority's (PSA) latest guidance in this area ('Good practice in making Council appointments', published July 2022) and still meets the PSA's requirements.
- 1.2 As set out in the policy, re-appointments occur when members are appointed for a further consecutive term, following a formal process to assess whether their skills and expertise continue to meet the needs of the Council but without having to go through further open competition (paragraph 10.1).

## 2. Possible re-appointments for 2023

- 2.1 Three members who were appointed as new members for a three-year term with effect from April 2020 will come to the end of that term on 31 March 2023. As members can serve for a maximum of eight years in a 20-year period<sup>1</sup>, the members concerned could serve a further term and are therefore eligible for re-appointment.
- 2.2 In December 2020, the Council considered the appointments and re-appointments schedule up to 2030. It was agreed then that a full appointments process should only take place every other year.

<sup>1</sup> The General Pharmaceutical Council (Constitution) Order 2010, SI 2010/300, s.3(2)

- 2.3 There were a number of reasons for these decisions, including the high turnover of Council members in 2019 and 2020 and the stability which retaining experienced members would provide in the early tenure of the new Chair. It was also expected that the GPhC would be in a period of change, including in ways of working and accommodation which was a further factor in favour of retaining some stability on Council. Finally, it allowed the significant cost of recruitment exercises to be more evenly spread.
- 2.4 The Council agreed that three members whose second terms would come to an end in 2022 should be re-appointed (if eligible and in agreement) for a third term of two years and these re-appointments went ahead in April 2022. In line with the staggering arrangements, it was also agreed in principle that two members whose second terms would come to an end in April 2023 should be re-appointed for a third term of one year.
- 2.5 We are therefore also looking to re-appoint the two members concerned for a third term of one year.
- 2.6 If Council remains in agreement, the schedule for member appointments and re-appointments in the next five years will be as follows:

2023	2024	2025	2026	2027
2 members re-appointed for final term of 1 year	5 new appointments	Gap year	3 possible re-appointments	Gap year
3 members re-appointed for 2 <sup>nd</sup> term of 3 years		Begin process for 3 possible re-appointments	5 new appointments	Begin process for 3 new appointments
Begin process for 5 new appointments		Begin process for 5 new appointments		

- 2.8 The Council needs to decide whether re-appointments will be made without open competition or whether an open competition should be run. The same decision must be made in relation to the whole of each cohort of members who are eligible for re-appointment – it is not permissible under PSA guidance to re-appoint some members but put others through an open competition. (The only circumstance in which a mixed process would be run would be if one or more members who are eligible for re-appointment decided that they did not wish to take up the option or where there are other very strong and documented reasons not to recommended reappointment, for example, linked to performance or conduct. Then it would be possible to run a re-appointment process for those members who wished to be re-appointed and an open competition to fill any vacancies).
- 2.9 All five of the members who would be eligible to be re-appointed have confirmed that they are interested in serving a second or third term respectively.

- 2.10 In accordance with the policy, if the Council agrees that re-appointments are appropriate, the members concerned will be asked to provide a statement of their case for re-appointment which the Chair will assess against the factors set out in the policy (see paragraph 10.10). The Chair will also take soundings from the Chairs of the Audit and Risk, Finance and Planning and Workforce Committees, where appropriate. In cases where this is not appropriate (such as when one of the members affected is one of those Chairs), the Chair will take soundings from the external member/s of the relevant committee.
- 2.11 We are not required to submit a formal Advance Notice to the PSA in respect of re-appointments in the way that we do for open competition. However, once candidates have been recommended, the PSA scrutiny and recommendation processes are the same and the re-appointments are formally made by the Privy Council.
- 2.12 We would be aiming to have the re-appointments process completed by February, depending on the length of time taken for the PSA and Privy Council Office (PCO) to complete their individual and consecutive parts of the process.
- 2.13 Given the agreed need to maintain a balance between refreshment and continuity on the Council, particularly in light of the appointment of a new Chair, there appears to be no reason why Council should not use the re-appointments process in this instance.

### **3. Equality and diversity implications**

- 3.1 Council has already considered the importance of achieving and maintaining a balance between stability and new members when deciding on the agreed 'staggering' arrangements. Part of that conversation included the efforts being made to increase the diversity of the Council, particularly through the dedicated diversity action plans now used in Council and Chair recruitment.
- 3.2 If approved, the use of re-appointments must apply to all members wishing to undertake a further term and therefore does not impact on the current diversity profile of the Council. We will continue to keep the focus on the diversity of Council in future appointment rounds.

### **4. Communications**

- 4.1 The PSA and PCO will be notified of the in-principle decision and the expected timetable as soon as possible after the decision has been made and we will keep them updated throughout the process. If the decision is to use the re-appointments process, there will be no need to advertise. However, if the decision is for open competition, a communications plan will need to be developed to underpin the recruitment campaign.

### **5. Resource implications**

- 5.1 The work needed to run a re-appointments process has been factored into our planning as it is in line with the previous staggering arrangements agreed by Council and requires no additional resource.
- 5.2 If the Council were to take a different approach, a full appointments process would need to be resourced and managed, at a cost of approximately £20k plus VAT per new member (based on the last two campaigns, which is in line with the market rate for these types of appointments).
- 5.3 There would also be additional costs for advertising and media, selection panel attendance fees and other costs such as those associated with reasonable adjustments.

## **6. Risk implications**

- 6.1 An appropriate re-appointments process is essential for good governance. Our procedures must meet the requirements of the PSA's scrutiny process in order for the PSA to have confidence in it, otherwise they would not recommend the process to the PCO and the requested re-appointments would not be made.

## **7. Recommendations**

The Council is asked to agree that the re-appointments process may be used to fill the vacancies which will arise on Council when five members complete a term of office on 31 March 2023, in line with the previous decisions taken on staggering.

Janet Collins, Senior Governance Manager  
General Pharmaceutical Council  
24/10/2022

# Minutes of the Audit and Risk Committee meeting held on 22 September 2022

## Minutes of the public items

### Present:

Neil Buckley (Chair)  
Helen Dearden  
Aamer Safdar

### Apologies:

Yousaf Ahmad  
Ann Jacklin  
Jayne Salt

### In attendance:

Duncan Rudkin	Chief Executive and Registrar
Carole Auchterlonie	Director of Fitness to Practise
Jonathan Bennetts	Director of Adjudication and Financial Services
Laura McClintock	Chief of Staff and Associate Director of Corporate Affairs
Gary Sharp	Associate Director of HR
Rob Jones	Head of Risk Management and Audit
Shugafra Akram	Head of Continuous Improvement (FtP)
Janet Collins	Senior Governance Manager
Tom Scott	Project Consultant
Saleem Akuji	Financial Controller
Ashley Norman	TIAA
Kelly Reid	TIAA

## 1. Attendance and introductory remarks

- 1.1 The Chair welcomed those present to the meeting. Apologies had been received from Yousaf Ahmad, Ann Jacklin and Jayne Salt.

## 2. Declarations of interest

- 2.1 The Chair reminded members of the committee to make any appropriate declarations of interest at the start of the relevant item.

## 3. Minutes of previous meetings – 26 May 2022 (22.09.ARC.01)

- 3.1 **The minutes of the public items considered at the meeting on 26 May 2022 were approved.**

## 4. Actions and matters arising – public items

- 4.1 The committee noted the action log. It was agreed that the committee would continue to look at risks relating to data, while the new Quality and Performance Assurance Committee would look at data as it related to performance and the Board Assurance Framework.
- 4.2 There were no matters arising in relation to public items.

## 5. Item 10 – Internal audit (22.09.ARC.07a-d)

- 5.1 Ashley Norman introduced this item.

*Summary internal controls assurance report (SICA)*

- 5.2 **The Committee noted the SICA.**

*Assurance review of Renewal programme*

- 5.3 Kelly Reid (KR) introduced the findings of this assurance review into the governance arrangements in place for phase two of the Renewal programme. The overall assessment was green (substantial assurance).
- 5.4 Governance arrangements for the Renewal programme were robust with Council, Renewal Board and Senior Management oversight and nominated workstream leads. Planning and communication was working well. Risks and benefits had been identified, documented and were regularly reviewed and updated. Documentation was available to staff on the intranet and a hybrid working policy was in place and had been provided to staff. There were no action points.

- 5.5 **The Committee noted the positive outcome of the assurance review.**

*Assurance review of Learning and Development (L&D)*

- 5.6 KR also introduced the review into the arrangements in place to maintain the training and education programme required to develop the organisation. The overall assessment was yellow (reasonable assurance). There were eight recommendations, three of which were classed as Important.
- 5.7 The Committee had concerns about the fact that at the time of the review (July 2022) only 61% of Performance Development Reviews (PDRs) had been completed and serious concerns that the completion for mandatory health and safety training was only 78%. Further concerns were expressed about how this reflected on the way that staff were being managed, which could impact on recruitment and retention.

- 5.8 Concerns were also expressed about the management responses set out in the report. The Committee was of the view that the overall assessment should be orange (limited assurance).
- 5.9 The Committee asked that the audit be shared with the Workforce Committee at its meeting on 30 September and that further reports be provided to that committee with metrics.
- 5.10 An updated management response would be provided to the Senior Leadership Group so that all directors were aware of the actions needed. That response would also be shared with the ARC by email.
- 5.11 With those actions in place it was agreed to leave the assurance level at yellow.
- 5.12 **The Committee noted the internal audit annual report.**

## **6. Item 15 – Never events and serious incident updates**

- 6.1 There were no never events or serious incidents to report other than the Registration Assessment issues in June which Council was fully aware of.

## **7. Any other business**

- 7.1 There was no other business.