General Pharmaceutical Council

Council meeting

Thursday, 07 December 2023

Public meeting at 13.10

Public business

Standing Items

13.10	**1. Welcome and introductory remarks**	Gisela Abbam
	2. Declarations of interest – public items	Gisela Abbam
13.10	**3. Minutes of the November meeting** *Minutes of the public session on 9 November 2023 – for approval*	**23.12.C.01** Gisela Abbam
13.15	**4. Actions and matters arising** • Update on the backlog in triage • Developments in pharmacy – Pharmacy First England	**23.12.C.02** Gisela Abbam
13.20	**5. Workshop summaries – October and November 2023** *For noting*	**23.12.C.03** Gisela Abbam
13.20	**6. Strategic communications and engagement - Chair and Chief Executive's update** *For discussion and noting*	**23.12.C.04** Duncan Rudkin
13.30	**7. Chair's reflections on 2023** *For noting*	**23.12.C.05** Gisela Abbam

Regulatory functions

13.45	**8.Tackling discrimination – revised hearings and outcomes guidance** *For decision*	**23.12.C.06** Hannah Fellows and Jerome Mallon
14.05	**9. Standards for Chief Pharmacists** *For approval for consultation*	**23.12.C.07** Annette Ashley

14.25	**10. Update from the advisory group on post-registration assurance of practice** *For discussion and noting*	**23.12.C.08** Ann Jacklin and Aamer Safdar
14.35	**11. Update on the status of the temporary register** *For discussion and noting*	**23.12.C.09** Mark Voce
14.45	**12. Assurance and Appointments Committee annual report to Council** *For discussion and noting*	**23.12.C.10** Elisabeth Davies

Governance, finance and organisational management

15.00	**13. Conflicts of interest and Gifts and hospitality policies** *For decision*	**23.12.C.11** Laura McClintock
15.10	**14. Minutes of the Audit and Risk Committee (public items)** *Draft minutes of the Audit and Risk Committee meeting held on 21 September 2023 - for noting*	**23.12.C.12** Neil Buckley
15.15	**15. Any other business**	Gisela Abbam

Confidential business[1]

Standing items

15.15	**16. Declarations of interest – confidential items**	Gisela Abbam
15.20	**17. Minutes of the October meeting**	**23.12.C.13**
	Minutes of the confidential session on 12 October 2023 – for approval	Gisela Abbam
	18. Matters arising	Gisela Abbam

Regulatory functions

15.20	**19. Update on PSA standard 15** *For noting*	**Oral update**

[1] 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.

Governance, finance and organisational management

15.25	**20. Investment review** *For discussion and decision*	**23.12.C.14** Mark Hammond and Jonathan Bennetts
15.35	**21. Appointment of internal auditors** *For noting*	**Oral update** Jonathan Bennetts
15.45	**22. Minutes of committee meetings:** a) Audit and Risk Committee, 21 September 2023 (confidential items) b) Quality and Performance Assurance Committee, 17 October 2023 c) Workforce Committee, 20 October 2023	**23.12.C.15 a-c** Gisela Abbam
15.50	**23. Any other business**	Gisela Abbam
	Meeting close	

Date of next meeting

Thursday 22 February 2024 – in person

2024 dates:

Thursday 18 April – online

Thursday 13 June – in person

Thursday 18 July – online

Thursday 12 September – online

Thursday 12 December – in person

(The October meeting will be an awayday in Scotland)

General Pharmaceutical Council

Minutes of the Council meeting held on 9 November 2023

To be confirmed on 7 December 2023

Minutes of the public items

Present:

Gisela Abbam (Chair)	Penny Mee-Bishop
Yousaf Ahmad	Rima Makarem
Neil Buckley	Arun Midha
Mark Hammond	Rose Marie Parr
Jo Kember	Aamer Safdar
Elizabeth Mailey	Jayne Salt

Apologies:

Ann Jacklin

Selina Ullah

In attendance:

Duncan Rudkin	Chief Executive and Registrar
Jonathan Bennetts	Director of Adjudication and Financial Services
Hannah Fellows	Interim Director of Fitness to Practise
Mark Voce	Director of Education and Standards
Laura McClintock	Chief of Staff and Associate Director, Corporate Affairs
David Hajduk	Associate Director, Technology
Gary Sharp	Associate Director, HR and OD
Siobhan McGuinness	Director for Scotland
Janet Collins	Senior Governance Manager

Standing items

1. Attendance and introductory remarks

1.1 Gisela Abbam (GA) welcomed those present to the meeting. Ann Jacklin and Selina Ullah had sent their apologies.

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 (23.11.C.01)

3.1 The minutes of the public session held on 12 October 2023 were approved as a true and accurate record of the meeting.

4. Actions and matters arising (23.11.C.02)

4.1 The action log was up to date. There were three matters arising:

Update on the November sitting of the registration assessment

4.2 Approximately 1200 candidates sat the assessment on 2 November without any delays or signficant issues. The team would be speaking to the British Pharmaceutical Students Association to get their feedback. Further details on the sitting, including pass rates, would be provided once the results had been published. Members asked for the further information to include reference to reasonable adjustments.

Lower Registration assessment pass rates for candidates from certain pharmacy schools (October minutes paragraph 7.3)

4.3 As mentioned at the October meeting, pass rates in the assessment for graduates of schools whose performance was a cause for concern would be analysed.

PSA performance review report 2022/23 (October minutes parapraph 8.3)

4.3 The GPhC had written to the Secretary of State and the Chair of the Health and Social Care Committee about the outcome of the PSA performance review and the plans to regain standard 15. The Secretary of State had acknowledged the letter and a Minister had requested further information. A response would be sent following the discussion with the Audit and Risk Committee which would take place on 15 November.

5. Strategic Communications and engagement report – Chair and Chief Executives update (23.11.C.03)

5.1 DR presented this item and specifically referenced the equality-focussed engagements described in paragraphs 2.7 and 2.8. The latest edition of Regulate had included an important reminder about professional behaviour online and the need for all patients to feel safe accessing pharmacy services and for pharmacy teams to feel safe at work.

5.2 Members discussed the opportunities for joint working with other regulators, sharing information on fitness to practise and the future membership of the UK Commission on Pharmacy Leadership.

5.3 Following the discussion, **the Council noted the update.**

6. Key developments in pharmacy – update (23.11.C.04)

6.1 Mark Voce presented the update which covered developments in four areas: regulation and professional leadership; pharmacy practice; healthcare; and pharmacy education and training.

6.2 The latest update also included key contacts in each area for members who wanted more information on a specific item.

Regulatory functions

7. Delivering equality, fostering inclusion and improving diversity: six-month strategic update, year 2 (23.11.C.05)

7.1 Mark Hammond declared an interest. The paper mentioned a training session for staff on religion and belief in the workplace, provided by the Religion and Belief Literacy Partnership with which he was involved. The training provider had been selected from a range of possible providers in line with the relevant procurement processes.

7.2 Laura McClintock (LM) presented this item which set out the main EDI activities carried out under each of the three strategic aims during Q1 and Q2 of 2023/24, which was the second year of the strategy.

7.3 A range of activites had been carried out and the agreed actions for year 2 were on track. There had been good levels of positive engagement with the strategy internally and externally and data collection to support later evaluation had begun.

7.4 LM highlighted certain activities under each theme, including the collection of EDI data from people raising FtP concerns and qualitative data about any barriers they faced; and analysis of EDI data in relation to FtP cases (under theme 1); the publication of a number of articles including a patient safety spotlight on the risks of prescribing and supplying HRT and the design and delivery of a language barriers and health inequalites roundtable (under theme 2); and further equality training and inclusive mentoring (under theme 3).

7.4 Following a discussion, **the Council noted the update.**

8. Strengthening pharmacy governance – draft guidance for Chief Pharmacists (23.11.C.06)

8.1 Annette Ashley (AA) presented the draft guidance for Chief Pharmacists.

8.2 The Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022 commenced on 1 December 2022. The Order extended the defences that already applied to pharmacy staff working in registered pharmacies to staff working in other relevant pharmacy services such as hospitals, care homes and prisons. The aim of this was to provide consistency across the pharmacy sector and enable and incentivise the reporting of preparation and dispensing errors.

8.3 In order to benefit from the defences as set out in the Order, the setting must have a Chief Pharmacists or equivalent in post who must be a registered pharmacist with the appropriate skills, training and experience. The Order gave the GPhC the power to set standards for the Chief Pharmacist role, including a description of their professional responsibilities. Where an organisation chooses to have a Chief Pharmacist in order to benefit from the defences, that person must meet the standards.

8.4 The development of the standards for Chief Pharmacists was the first part of a programme of work to strengthen pharmacy governance, which also included the production of Rules and professional standards for Responsible Pharmacists and professional standards for Superintendent Pharmacists in 2024/25.

8.5 The paper outlined the extensive engagement which had taken place during the development of the draft standards.

8.6 The draft standards were outcome-focussed, as they would be required in a wide range of settings and needed to apply to them all. There were discussions with the Department of Health and Social Care and relevant pharmacy bodies about who should produce additional guidance to support Chief Pharmacists in meeting the standards.

8.7 The four standards which Chief Pharmacists must meet were:

- Provide strategic and professional leadership;
- Develop a workforce with the right skills, knowledge and experience;
- Delegate responsibly and make sure there are clear lines of accountability; and
- Strengthen governance to ensure safe and effective delivery of pharmacy services.

In the draft, each standard was suppported by examples of how they could be met in practice.

8.8 The draft standards had been discussed with the Post-registration Assurance of Practice advisory group on 8 November and the group had suggested that EDI should be more explicit. The team agreed with this and AA asked Council members whether there were other points that should have more emphasis in the draft. The consultation was due to be launched in January 2024 and so there was still time for feedback on the draft.

8.9 The standards would need to align with those of other regulators such as the Care Quality Commission, Healthcare Improvement Scotland, the Health Inspectorate Wales and the Medicines and Healthcare products Regulatory Agency and were being discussed with them.

8.10 The Council discussed how compliance with the standards would be monitored and enforced.

8.11 Following the discussion, the Council agreed that further revisions should be made to the draft standards, which would then be brought back to the December meeting for approval for consultation.

9. Update from the advisory group on the Initial Education and Training of Pharmacists (23.11.C.07)

9.1 Rose Marie Parr (RMP) and Arun Midha (AM) presented the update.

9.2 The recent work of the group had been focussed on the implementation of experiental learning, clinical placements and prescribing; and the accreditation of universities to the new standards. RMP and AM paid tribute to the way in which the bodies involved were working together and sharing learning on some difficult issues such as curriculum design and deliver, clinical placements and ensuring that there were enough Designated Prescribing Practitioners to sign off trainees.

9.3 **The Council noted the update.**

Governance, finance and organisational management

10. Fee review decision (23.11.C.08)

10.1 Jonathan Bennetts (JB) presented this item, which set out the analysis of responses to the fees consultation and proposed changes to the fees charged to GPhC registrants. All registrant members of Council declared an interest.

10.2 It was important to recognise the strong opposition to fee increases expressed in the responses, the themes of which had been collated and responded to in the paper. However, it was also important to recognise that the work of the GPhC was almost exclusively funded by fees and that, when setting fees, the Council must ensure that the organisation had sufficient funds to protect the public through effective regulation.

10.3 The current model of maintaining fees at the same level for several years and then having to raise them by a significant percentage was not welcomed by registrants and there was a need to move to a different model, possibly of more regular incremental increases.

10.4 Differential fees for different types of pharmacies (physical and online) were a possibility that would be considered.

10.5 The responses showed that respondents did not accept the rationale for the increase. Members were of the view that the organisation could do more to explain its role effectively to registrants and needed to be clearer about its role in maintaining public confidence in a regulated pharmacy profession. It would be important to be clear with registrants that their views had been listened to, while explaining the challenges of running a regulated profession, where their fees went including where savings had already been made and work that was planned.

10.6 Other important facts were that fees had not been increased since 2019 and were lower than they had been in 2011. It would also be helfpul to emphasise that fees could be paid in quarterly installments. Monthly direct debit could also be considered, although that could be complex.

10.7 Following the discussion, the Council:

- **Noted** the analysis of consultation responses on the 2023 fee review;
- **Noted** the equality impact assessment;
- **Approved** a 7.5% increase to all fees for pharmacists, pharmacy technicians, registered premises and foundation training from April 2024; and
- **Made the General Pharmaceutical Council (Registration and Renewal Fees) (Amendment) Rules 2023 and authorised the corporate seal being applied to the Rules.**

10.8 The consultation and its analysis had taken a lot of work from multiple staff and JB thanked them.

11. Board Assurance Framework report – Q2 2023/24

11.1 DR presented the Board Assurance Framework report for Q2 and introduced Kieron Jones, the Head of Inspection, to the Council.

11.2 DR highlighted the sections on timeliness in Fitness to Practise (FtP), capacity and the new target operating model. The current re-structure was partly designed to allow staff resources to work across teams more effectively.

11.3 HR was showing amber due to an increase in sickness absence, and Inspection due to a particularly complex enforcement action which was taking longer than expected.

11.4 There was a short-term backlog at the triage stage of FtP due to an increase in concerns being received. This meant that there was a risk that urgent concerns describing a risk to patient safety might not be picked up quickly, so mitigation had been put in place and all incoming concerns were subject to an early review, with any that might indicate a risk being dealt with more quickly. The Council would be updated on this issue at the next meeting.

11.5 Following the discussion, **the Council noted the Board Assurance Framework report for Q2.**

12. Any other business

12.1 DR reminded members that the next stakeholder roundtable would be held in London on 6 December, the evening before the Council meeting. The roundtables were important opportunities to listen to stakeholders and hear about the isses that matterred to them, so all members were encouraged to attend if possible.

12.2 There being no further business, the public meeting closed at 3.30 p.m.

General Pharmaceutical Council

Council action log – December 2023

	Open and on track
	Overdue
	Rescheduled
	Complete

No.	Status	Minutes	Action	Lead	Update	Due date
8	Open	December 7.6	Further status update on the temporary register to be provided in 12 months	MV	On the agenda for this meeting	December 2023
9	Open	November 8.11	Draft standards for Chief Pharmacists to be further revised and brought back to the December meeting for approval for consultation	MV	On the agenda for this meeting	December 2023

General Pharmaceutical Council

Council workshop summaries

Meeting paper for Council on 07 December 2023

Public

Purpose

To provide an outline of the workshop discussions at the Council meetings on 12 October and 9 November 2023.

Recommendations

The Council is asked to note the discussions from the October and November workshops.

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 in 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. October workshop summary

(a) Assessment and Assurance strategy for initial education and training

2.1 Mark Voce (Director of Education and Standards) introduced this session, which set out how standards, quality assurance and assessment worked together to ensure that pharmacy professionals entering the GPhC register had met the necessary standards. The session also sought initial views from Council on the approach to assessing pharmacy professionals in the future.

2.2 During the session members discussed the following in groups:

- whether a national assessment was still needed;
- if so, whether changes were needed; and
- whether, if some form of assessment was retained, one should also be introduced for pharmacy technicians.

2.3 Key stakeholder views were discussed, as was a draft set of principles which should apply to the development of any new assessment. These included trainee wellbeing and equality, diversity and fairness.

(b) Session with specialist inspectors

2.4 Neha Ramaiya (Senior Clinical Pharmacy Advisor and Specialist Inspector) led this session which was also attended by several other specialist inspectors. The session covered the work of the specialist inspectors, projects that they worked on within the GPhC and their external engagement.

2.5 In addition to supporting inspection activities and taking part in the training of inspectors, another important aspect of the role was to enhance the clinicals skills base internally, allowing more effective assessment of the quality of clinical pharmacy services.

(c) Strategic aim 2 progress review and scorecard

2.6 Claire Bryce-Smith led this session which looked at the further development of metrics for strategic aim 2 ('Deliver effective, consistent and fair regulation') and presented a draft scorecard, developed at Council's request, for members to discuss.

3. November workshop summary

(a) National Pharmacy Association (NPA)

3.1 Nick Kaye (Chair) and Gareth Jones (Director of External Corporate Affairs) of the NPA presented a session on the work of the Association and current perspectives on community pharmacy.

3.2 The session included the increasing clinical opportunities for community pharmacy, funding and workforce challenges and medicine supply chain issues and also examined the future of community pharmacy.

3.3 The presentation was followed by a discussion on the future of community pharmacy, with access to patient records, locating pharmacies where patients needed them and changes to contracts identified as major factors.

(b) Pharmacy technician education and training

3.4 Mark Voce and Damian Day (Head of Education) presented this session, which covered the current pharmacy technician context and education and training standards. Pharmacy technician practice was widely diverse and this was likely to continue to be the case.

3.5 Pharmacy technicians were increasingly seen as fundamental to achieving improvements across the provision of healthcare. There were clear government plans to grow the workforce and expand their scope of practice, as more pharmacists became prescribers and multi-disciplinary teams working across a range of settings developed. With proposals to enable pharmacy technicians to administer medicines under Patient Group Directions, there needed to be discussions about the necessary levels of education and training.

3.6 The GPhC was developing new education and training standards, with an aim to consult on them in 2024/25. Research by the Centre for Pharmacy Studies to support the development of the new standards would be reported back to Council in Q4.

3.7 There would also be a need to focus on pharmacy technicians who were currently registered and practising – this would be covered by the work of the Post-Registration Assurance of Practice group. The group would look at revalidation, how far additional training should be required and how far it should be a matter for employers and pharmacists to identify individual needs.

3.8 Members discussed the issues raised in the presentation, possible qualification levels and career pathways.

4. Recommendations

The Council is asked to note the discussions from the October and November workshops.

Janet Collins, Senior Governance Manager
General Pharmaceutical Council

21/11/2023

General Pharmaceutical Council

Strategic communications and engagement: Chair and Chief Executive update

Meeting paper for Council on 07 December 2023

Public

Purpose

To update the Council on Chair and Chief Executive strategic communications and engagement since the last meeting on 9 November 2023.

Recommendations

Council is asked to note and discuss the update.

1. Introduction

1.1 This paper updates Council on key insights and information arising from Chair and Chief Executive strategic engagements and wider events, as a regular standing item.

2. Strategic engagements: November to December 2023

2.1 Below is a summary of key engagements and the issues discussed since the last Council meeting on 9 November 2023.

Policy makers (including parliamentarians and Government officials)

2.2 On 28 November, the Chair and Chief Executive visited No.10 Downing Street, following an invitation to meet with the Prime Minister's Special Adviser on health. Key topics for discussion included: education and training reforms; the role of pharmacist prescribers; integration of patient records across primary care including pharmacy; pressures on pharmacists, pharmacy technicians and pharmacy businesses; medicines shortages; skill mix in pharmacy and important forthcoming legal reforms.

2.3 In this period, the Chief Executive also met with the Department of Health and Social Care to discuss the follow up to the Government's earlier consultation on 'hub and spoke' dispensing. The consultation (which ran from March to June 2022) included proposals to enable all community pharmacies to benefit from 'hub and spoke' models, with the intention of supporting efficiencies for pharmacies.

NHS and pharmacy leaders

2.4 The Chief Executive (and our Director for Wales) met with the Chair of the RPS Welsh Board and the RPS Director for Wales on 15 November. Discussions focussed on respective

priorities, including engagement in Wales and other key pharmacy developments. Our Chair also met with the President of the RPS on 24 November.

2.5 The Chair and Chief Executive met with the Chief Workforce, Training and Education Officer at NHS England and the Chief Pharmaceutical Officer for England on 22 November. The discussion included a review of the progress of the implementation of the IET standards for pharmacists, recognising the collaborative work from both organisations; the process for the GPhC to accredit NHSE in relation to foundation training; and, planned workforce reform of education and training for pharmacy technicians.

Regulatory leaders

2.6 The Chief Executive attended a meeting with the Chief Executives of the regulatory bodies on 29 November. The group discussed several issues of relevance to the health and care regulators, including approaches to social media guidance for professionals as well as ongoing priorities such as regulatory reform.

Other strategic engagement events

2.7 The Chief Executive presented at the UK Sigma Community Pharmacy Conference on 5 November 2023. Sigma is one of the largest independent wholesalers in the UK. Other presenters included Lord Dolar Popat (Prime Minister's Trade Envoy to Rwanda, Uganda and DRC), Steve Brine MP (Chair, Health and Social Care Committee) and various community pharmacy leaders.

2.8 The Chair attended the AIMP Annual Award ceremony on 1 November, and attended an event run by the Royal Institute of International Affairs on 'Fostering inclusive health systems' on 21 November 2023.

2.9 The Chair and Chief Executive attended the RPS Annual Conference on 10 November 2023, focussed on 'Working Together: Empowering the Workforce to Transform Patient Care'.

3. Next steps

3.1 We have further strategic engagements planned between now and the next Council meeting in the new year, including meetings with key stakeholders and our regional roundtables and forum events. Further updates on these engagements will be shared in our next update report to Council.

4. Recommendations

Council is asked to note and discuss the update.

General Pharmaceutical Council

30/11/2023

General Pharmaceutical Council

Chair's end of year reflections

Note for Council on 07 December 2023

Public

At the end of my first full calendar year as Chair of the GPhC, I want to share some brief reflections, thinking particularly about our achievements as well as some of the challenges we have faced together.

This is an exciting time for the pharmacy professions as the role of pharmacy is rapidly evolving. Pharmacy teams and pharmacies are increasingly providing more clinical care and services to patients, playing a crucial role in alleviating pressures within the NHS and in social care, and in reducing the backlog. But I know it is a time of challenges too. I want to thank everyone in the pharmacy sector for your vital work during the pandemic and continued work to protect the public in challenging times.

I have been proud to participate in our series of equality focussed roundtables this year, including on racism in pharmacy and on language barriers and health inequalities. The GPhC has been rightly putting tackling inequalities and exclusion at the forefront of our work. Addressing inequality and exclusion is fundamental to the GPhC's core purpose as a regulator and our vision for safe and effective pharmacy care at the heart of healthier communities. This includes the public we serve and the professions we regulate.

Over the last year I have been spending time meeting with and listening to a wide range of stakeholders including pharmacy professionals, students and trainees, pharmacy owners, patients, and members of the public. Genuinely listening to the views and experiences of our stakeholders and finding out what matters to them is important to me and the GPhC. Ultimately it helps inform our work and build our insights into key issues. I have enjoyed the opportunity to meet stakeholders at our five regional roundtables events held this year as well as listening into the discussions of our Student Voice, Patient and Public Voice, and Pre-registration Trainee Pharmacy Technician Forums meetings. Everything I have heard has helped to shape my thinking and approach as Chair.

I recognise that this has been an exceptionally busy year for everyone at the GPhC, and I would like to thank the Council members, the Executive team and the staff for their dedication and commitment.

There is not enough time to cover everything here, but I wanted to mention a few points:

- Pharmacy continues to change at pace, with a much broader range of clinical services being delivered as well as a much greater use of technology enabled models of service delivery. Patients and the public are accessing medicines in new ways, and we are seeing more varied and complex business models and more services being offered online. It is essential that regulation keeps pace with these changes to ensure patients and the public are protected and receive safe and effective pharmacy care. One example is our new team of Specialist Inspectors and Clinical Pharmacy Advisers, who have enhanced our clinical skill base internally to enable us

to effectively assess the quality of clinical services. This team are from a variety of clinical backgrounds working across a range of sectors and are all independent prescribers.

- Ensuring pharmacy professionals are equipped for their future roles and continue to be after registration is another significant area of work for the GPhC. I am looking forward to engaging on Education and Training for Pharmacy Technicians. I would like to thank the Advisory Group for the Initial Education and Training of Pharmacist and the Advisory Group on Post-registration Assurance of Practice for their continued commitment and work over the last year. I am also pleased that the GPhC has joined a new group, led by the Royal Pharmaceutical Society (RPS) to address the differential attainment and awarding gaps experienced by black pharmacy students and Foundation Trainees.
- I was pleased that the GPhC met 17 out of 18 of the Professional Standards Authority for Health and Social Care (PSA) Standards of Good Regulation during 2022/23. However, there is still more work to be done to achieve all of the desired standards. A dedicated cross-organisational programme of work is in place to ensure this happens.
- I am reassured to see the GPhC continue to develop, with a new executive structure that will ensure that our organisation is driven by desired outcomes set out in our vision, rather than by process and procedures. I am delighted to welcome Roz Gittins as Chief Pharmacy Officer and Deputy Registrar, and Dionne Spence as Chief Enforcement Officer and Deputy Registrar. These new chief officers will join existing staff members Mark Voce in his new role as Chief Strategy Officer and Deputy Registrar and Jonathan Bennetts as Chief Operating Officer & Deputy Registrar.

Looking ahead to next year, it's clear to see that things are continuing to develop at pace in pharmacy regulation. In the new year we will be launching our consultation on draft standards for Chief Pharmacists, part of our strengthening pharmacy governance programme of work. This programme aims to provide clarity around how pharmacies are organised and managed to help us to make sure patients and the public continue to receive safe and effective pharmacy care.

We also plan to hold more listening roundtables across the country, and I hope to visit more community pharmacies. We also plan to collaborate with a wider range of stakeholders in the coming year.

Furthermore, I look forward to continuing to work alongside the Council, the Executive and the staff on our shared Vision of safe and effective pharmacy care at the heart of healthier communities.

Below is a list of some of the key meetings and activities I have attended in 2023.

Gisela Abbam, Chair (7 December 2023)

List of key meetings and activities

Date	Meeting with
6 January 2023	UK Commission Stakeholder meeting
25 January 2023	Inclusive Pharmacy Practice Advisory Board Meeting
1 March 2023	UK Black Pharmacist Association
21 March 2023	Improving patient safety workshop
17 April 2023	Pharmaceutical Society of Northern Ireland

Date	Meeting with
28 April 2023	Association of Pharmacy Technicians UK
2 June 2023	General Dental Council
30 June 2023	Pharmacist Support
10 July 2023	Professional Standards Authority roundtable discussion for Health and Social Care Professions Regulator's Chairs
9 August 2023	General Medical Council
16 August 2023	Visit to Day Lewis pharmacy
8 September 2023	Royal Pharmaceutical Society
8 September 2023	Pharmacist Support
19 September 2023	APPG Pharmacy Stakeholder Roundtable Event
25 October 2023	Pharmacist Support
25 October 2023	General Medical Council
1 November 2023	Nursing and Midwifery Council
22 November 2023	NHS England
24 November 2023	Royal Pharmaceutical Society President
28 November 2023	Meeting at No.10 Downing Street

Conferences and events

Date	Activity
8 March 2023	GPhC Student Voice forum
14 March 2023	GPhC Regional roundtables event, London
15 March 2023	GPhC Patient Voice forum
22 March 2023	Women Innovating Together in Healthcare
21 March 2023	GPhC Pre-registration Trainee Pharmacy Technician forum
28 March 2023	Westminster Health Forum - Next steps for pharmacy in healthcare delivery, and developing the role of community pharmacy in England (speaking event)
19 April 2023	Royal Pharmaceutical Society - Building Confidence: key to achieving Gender Equality in Pharmacy
26 April 2023	Women in Pharmacy reception at the House of Commons
6 June 2023	Professional Standards Authority's symposium - How can we successfully collaborate towards safer care for all?
4 July 2023	GPhC Regional roundtables event, Wrexham

Date	Activity
5 July 2023	Reception to mark 75 years of the NHS at 10 Downing Street
18 September 2023	GPhC Language barriers and health inequalities roundtable
10 October 2023	GPhC Racism in Pharmacy roundtable
15 October 2023	The Pharmacy Show
15 October 2023	GPhC Regional roundtables events, Birmingham
1 November 2023	AIMP Annual Award Ceremony
10 November 2023	RPS Conference
21 November 2023	Chatham House
6 December 2023	GPhC Regional roundtables event, London

Tackling potential discrimination and bias: consultation on our hearings and outcomes guidance

Meeting paper for Council on 07 December 2023

Public business

Purpose

To provide the Council with our revised hearings and outcomes guidance, background and context to the work, a summary of the changes we have made since the consultation exercise and a report on the feedback from the consultation exercise.

Recommendations

The Council is asked to:

- Note the analysis report from the consultation exercise (Appendix 1)
- Note the proposed changes to the guidance (summarised in this paper)
- Agree the revised guidance (Appendix 2).

1. Introduction

1.1 Equality, diversity and inclusion (EDI) is central to everything that we do and is woven into our Vision 2030 and Strategic Plan 2020-2025, which set out our roadmap for the future of pharmacy regulation. Furthermore, it is a key part of our *Managing concerns about pharmacy professionals* strategy, which Council approved at its meeting in June 2021. We also have specific commitments in our EDI strategy relating to our regulatory decision making and a number of Fitness to Practise related initiatives have been completed and reported to Council in the recent Year 1 report for 2022/23.

1.2 In November 2022, we consulted on changes to our hearings and outcomes guidance for decision-makers, to strengthen our approach to dealing with cases involving discrimination, harassment and bullying, and to include new information about cultural factors when panels are deciding on an outcome. The exercise concluded in January 2023. As part of this exercise, we sought views on a number of important proposals to strengthen our guidance for decision makers.

1.3 We delivered this consultation paper through a survey, which received a total of **218** written responses: **204** of the respondents identified themselves as individuals and **14** responded on behalf of an organisation. Of these responses, **215** had responded to the consultation survey (**204** individuals and **11** organisations). We received **3** responses from organisations writing more generally about their views. 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 the key changes we are proposing to make to the guidance.

1.5 Following the consultation, we also engaged with a subgroup of Council members to discuss stakeholder feedback and seek their input into the final draft of the guidance, as presented with this paper.

2. Background

2.1 Health and social care regulators have been criticised for not taking racism and discriminatory behaviour seriously enough and, as such, are underestimating the impact that these concerns are having on public confidence and trust in the professions that they regulate. The Professional Standards Authority in its *Safer care for all – solutions from professional regulation and beyond* report has called for regulators to review how their fitness to practise processes, including their indicative sanctions guidance, address allegations of racist and other discriminatory behaviour. It's important to say that our work to strengthen the guidance started before the publication of the PSA report and was driven by our EDI and managing concerns strategies. Nevertheless, we have taken account of the PSA report as the work developed.

2.2 There is no place for discrimination in health and care and we are committed to making positive changes to play our part in tackling all forms of discrimination.

2.3 As a regulator, it is vital that we lead by example when tackling all forms of discrimination. We have a responsibility to make sure that our processes, policies and guidance are clear and that we take these concerns seriously when they are raised with us. We also want to make sure that not only are we taking concerns of this nature seriously but that we are tackling any potential bias in our decisions and that they are fair.

2.4 In our **Managing Concerns strategy,** we committed to managing the concerns we receive in a way that is free from discrimination and bias. Part of this commitment involves taking appropriate action when concerns are raised about discriminatory behaviour by pharmacy professionals and taking relevant external expert advice on such matters where necessary. Additionally, in the strategy, we said that we will support people to make non-discriminatory regulatory decisions.

2.5 In our organisational-wide **EDI strategy**, we also committed to making regulatory decisions that are demonstrably fair and free from discrimination and bias.

2.6 These strategies are interconnected. They each have a clear focus on how we will minimise and deal with the risk of potential biases in our decision-making and how we will manage concerns about discrimination.

2.7 To deliver on our published strategy commitments, we want to strengthen our hearings and outcomes guidance to address how decision makers should consider concerns about discrimination. The strengthened guidance will also look at taking account of cultural factors when professionals are demonstrating insight, for example when expressing an apology. Our aim is to be clear about how seriously concerns of this nature need to be taken and that fitness to practise decision makers should, when deciding on an outcome, take into consideration the seriousness of any discriminatory behaviour.

2.8 Once Council has approved the guidance we will take forward an implementation plan.

3. Summary and analysis of responses to consultation

3.1 The consultation analysis report (Appendix 1) provides a full breakdown of qualitative and quantitative responses.

3.2 The consultation sought views on two areas of the guidance: strengthening the section on taking account of cultural sensitivities; and an additional section on managing concerns that have discrimination as a key component. Respondents' views on these aspects are summarised below.

Part A: Views on inclusion of discriminatory behaviour section in the guidance

3.3 The inclusion of the proposed text on discriminatory behaviour in the hearings and outcomes guidance received strong support from respondents. The majority of respondents (76%) agreed with the proposed text to be included in the guidance, while only 14% of respondents indicated that they were in opposition to it.

3.4 Respondents generally expressed positive views in the explanatory comments on this proposal. Agreeing with the text, many respondents felt that discrimination exists and needs to be addressed. Respondents thought that providing guidance on the seriousness of discriminatory actions in the workplace and personal settings is helpful and should be considered in the decision-making. Moreover, many respondents found the statements included in the proposed text to be accurate and fair. However, some further clarifications were requested, particularly definitions of the terminology used, more examples on treatment cases and other forms of discrimination not already outlined in the guidance. Additionally, some respondents felt that the proposed changes are too stringent by showing concern with sanctions placed at the upper end of the scale and called for more leeway for the panel when making decisions.

3.5 Mitigating factors and regular case-by-case reviews were also emphasised for a more holistic approach. Some respondents who disagreed thought that the proposed text will lead to restrictions to freedom of speech and stifle debate. It was also remarked by some respondents, in support of the proposal, that there should be consideration given to mental health issues, nationality and other groups as well as circumstances relevant to the guidance.

Part B: Views on inclusion of cultural factors in insight, remediation, and testimonials in the guidance

3.6 A majority of respondents (66%) agreed with the proposed text on cultural factors in insight, remediation and testimonials to be included in the guidance. In contrast, only 18% of respondents disagreed with the proposed text.

3.7 In support of inclusion of the text, respondents acknowledged that differences across cultures and different communication styles should be considered in the guidance. There was an expressed view that this will help remove bias and stereotyping and accommodate understanding of underlying differences in showing remorse.

3.8 On the other hand, many organisational respondents requested more information on how this will be applied in practice, ensuring the panel's representation and knowledge of cultural backgrounds. Respondents also felt that the proposed text will raise awareness of cultural factors among pharmacy professionals that need to be considered in their work. Furthermore, similar concerns were raised here regarding the severity of sanctions as seen

under question 1. Some individual respondents were in opposition and believed that cultural factors should not be considered in the fitness to practise processes and that GPhC should be culturally neutral.

Council subgroup feedback

3.9 The subgroup reviewed the proposed changes that took account of feedback from the consultation and suggested further amendments, in particular, to strengthen what we mean by lawful and unlawful discrimination and the context in which these concerns can occur.

4. Summary of main changes

4.1 The following proposed changes are the outcome from considering the responses and discussing the proposals with equality, diversity and inclusion colleagues and the Council subgroup. Key changes include:

- Strengthening the committee's considerations around expressing insight, remorse and apology to include neurodiversity
- Adding further information around the weight of testimonials and how they should impact decision-making
- Clarification around definitions of different types of discrimination and strengthening information around the context in which it may occur
- Providing further examples of when discrimination may occur
- Change to the wording about the highest outcome to *usually* (rather than implying it's always) to be used where discrimination has been found.

4.2 We are also making a number of other changes to the guidance. This includes a changes to the language to improve consistency with similar decision-making guidance, and the title of the document to 'hearings and outcomes guidance' to better reflect the content and terminology we use.

4.3 Please note that as the changes are targeted in specific areas we have highlighted the changes using green and yellow. The green indicates what we originally proposed and the yellow indicates what we changed after the consultation exercise.

Further work to address some aspects of the feedback

4.4 There were a number of pieces of feedback that don't directly impact the guidance and will be taken forward in other ways.

4.5 This includes:

- The provision of additional resources for pharmacy professionals to help enhance understanding of differences in cultural behaviours and values
- Exploring the development of case studies involving discriminatory behaviour, feature articles in regulate and using the website to share examples of notable practice
- A review of any other guidance that may be impacted
- The provision of case studies and other training materials for committees

- A review of the Initial Assessment stage to ensure a consistent approach to concerns that involve discrimination

5. Equality and diversity implications

5.1 The first theme of our EDI strategy is "to make regulatory decisions that are demonstrably fair, lawful, and free from discrimination and bias". This work is one part of the actions we are taking to deliver against this objective, to tackle any discrimination, bias and lack of inclusion in the fitness to practise process.

5.2 Our equality impact analysis considerations have also been informed by our qualitative and quantitative analysis of responses to the consultation and the available evidence relating to groups by reference to protected characteristics.

6. Communications

6.1 The consultation analysis and the final version of the guidance will be published on the GPhC's website. It will also be sent to a wide range of stakeholders and communicated to the pharmacy media.

6.2 Our Associates and Partners will receive a tailored communication as the changes directly impact their roles.

7. Resource implications

7.1 The resource implications for this work have been accounted for in existing budgets and will be accounted for in budget projections and future budgets across the implementation period.

8. Risk implications

8.1 Whilst we are committed to ensure that our approach to decision making is fair and free from discrimination and bias, we also recognise that this approach is one of many measures to achieve this, and therefore, the approach set out in this paper should not be regarded as a 'stand – alone' intervention.

8.2 This work takes account of, and is aligned with, the Councils risk management policy in particular the risk appetite statement section on patient and public safety.

9. Monitoring and review

9.1 As we implement the new guidance we will also be evaluating the impact of the changes. We have already started to develop the evaluation programme including identifying the relevant data and evidence to support the evaluation exercise. Our quality review group (QRG) is planning a themed review of decisions around EDI issues and that it could include looking at the impact of this guidance. We will periodically report to Council on the evaluation.

10. Recommendations

The Council is asked to:

- Note the analysis report from the consultation exercise (Appendix 1)
- Note the proposed changes to the guidance (summarised in this paper)
- Agree the revised guidance (Appendix 2).

Hannah Fellows, Interim Director of Fitness to Practise
General Pharmaceutical Council

Jerome Mallon, Senior Policy and Planning Manager
General Pharmaceutical Council

07 December 2023

General Pharmaceutical Council

Discussion paper on supporting good decision making at hearings: analysis report

Contents

Executive summary

Background

Discrimination and discriminatory behaviour can have a significant impact within healthcare settings on both professionals and people receiving care. Healthcare professionals should treat patients and colleagues with dignity and respect, and regulators themselves must be clear about how they manage concerns about discrimination.

To tackle this, and to deliver on our published strategy commitments, we want to strengthen our hearings and outcomes guidance. Our aim is to be clear about how seriously concerns of this nature need to be taken, and how fitness to practise decision makers should, when deciding on an outcome, take into account the seriousness of any discriminatory behaviour.

Strengthening the guidance will guide fitness to practise committees on concerns that involve discrimination, and how to consider some aspects when there are cultural sensitivities.

We published a discussion paper on 29th November on proposed changes to the current hearings and outcomes guidance. The discussion paper covered two main areas:

- supporting decision making in hearings where discrimination is a factor
- taking account of cultural factors when panels are deciding on an outcome.

We delivered this discussion paper through a consultation survey, which received a total of **218** written responses: **204** of the respondents identified themselves as individuals and **14** responded on behalf of an organisation. Of these responses, **215** had responded to the consultation survey (**204** individuals and **11** organisations). We received **3** responses from organisations writing more generally about their views.

Key issues raised in responses

Views on inclusion of discriminatory behaviour section in the guidance

The inclusion of the proposed text on discriminatory behaviour in the hearings and outcomes guidance received strong support from respondents. The majority of respondents (76%) agreed with the proposed text to be included in the guidance, while only 14% of respondents indicated that they were in opposition to it.

Respondents generally expressed positive views in the explanatory comments on this proposal. Agreeing with the text, many respondents felt that discrimination exists and needs to be addressed. Respondents thought that providing guidance on the seriousness of discriminatory actions in the workplace and personal settings is helpful and should be considered in the decision-making. Moreover, many respondents found the statements included in the proposed text to be accurate and fair. However, some further clarifications were requested, particularly definitions of the terminology used, more examples on treatment cases and other forms of discrimination not already outlined in the guidance. Additionally, some respondents felt that the proposed changes are too stringent by showing concern with sanctions placed at the upper end of the scale and called for more leeway for the panel when making decisions.

Mitigating factors and regular case-by-case reviews were also emphasised for a more holistic approach. Although there has been a great appreciation for highlighting the need to understand and reflect the

diversity within the profession and population, some respondents who disagreed thought that the proposed text will lead to restrictions to freedom of speech and stifle debate. It was also remarked by some respondents, in support of the proposal, that there should be consideration given to mental health issues, female pharmacists, nationality and other groups as well as circumstances relevant to the guidance.

Views on inclusion of cultural factors in insight, remediation, and testimonials in the guidance

A majority of respondents (66%) agreed with the proposed text on cultural factors in insight, remediation and testimonials to be included in the guidance. In contrast, only 18% of respondents disagreed with the proposed text.

In support of inclusion of the text, respondents acknowledged that differences across cultures and different communication styles should be considered in the guidance. There was an expressed view that this will help remove bias and stereotyping and accommodate understanding of underlying differences in showing remorse.

On the other hand, many organisational respondents requested more information on how this will be applied in practice, ensuring the panel's representation and knowledge of cultural backgrounds. Respondents also felt that the proposed text will raise awareness of cultural factors among pharmacy professionals that need to be considered in their work. Furthermore, similar concerns were raised here regarding the severity of sanctions as seen under question 1. Some individual respondents were in opposition and believed that cultural factors should not be considered in the fitness to practise processes and that GPhC should be culturally neutral.

Views on the impact of the proposed changes on people sharing protected characteristics

Half of the respondents (51%) felt that the proposed texts on discriminatory behaviour and cultural factors in insight, remediation and testimonials would have a positive impact on groups or individuals who share any of the nine protected characteristics. Only 7% of respondents thought these groups or individuals will be negatively impacted by the proposed texts, 21% said this will result in both positive and negative impact, and 7% indicated no impact.

Respondents expressed mixed views in the explanatory comments on the impact the inclusion of the proposed texts will have. Many respondents shared the view that this will make fitness to practise processes fairer, especially for the minorities, and hoping that this will give people confidence to report unacceptable behaviour. Members of the public will also be positively impacted as the guidance will reassure the public that the GPhC aims to protect them when faced with discrimination. However, many respondents still felt that more information on how this will be implemented is required, and that the panel should be aware and sensitive to many issues during hearings such as non-verbal cues or sight impairment.

Respondents stressed that the visible focus in the proposed texts on particular protected characteristics, such as race and religion, is at risk of creating an impression of hierarchy. As a result, more examples for the rest of the nine characteristics should be provided. Although the majority of respondents felt this will have a positive impact, some emphasised situations where there may be both positive and negative impact depending on the case at hand. For example, a protected characteristic such as age may be a necessitating factor in a clinical decision and this may potentially be viewed as discriminatory. Lastly, some individual respondents emphasised their overall negative views towards the proposed changes

and showed general disagreement with the focus on Equality, Diversity and Inclusion in the hearings and outcomes guidance.

Introduction

Policy background

Health and social care regulators have been criticised for not taking racism and discriminatory behaviour seriously enough and, as such, are underestimating the impact that these concerns are having on public confidence and trust in the professions that they regulate. The Professional Standards Authority in its *Safer care for all – solutions from professional regulation and beyond* report has called for regulators to review how their fitness to practise processes, including their indicative sanctions guidance, address allegations of racist and other discriminatory behaviour.

There is no place for discrimination in health and care and we are committed to making positive changes to play our part in tackling all forms of discrimination. Equality, diversity and inclusion (EDI) is central to everything that we do and is woven into our Vision 2030 and Strategic Plan 2020-2025, which set out our roadmap for the future of pharmacy regulation.

As a regulator, it is vital that we lead by example when tackling all forms of discrimination. We have a responsibility to make sure that our processes, policies and guidance are clear and that we take concerns seriously when they are raised with us. We also want to make sure that we are tackling any potential bias in our decisions and that they are fair.

In our **Managing Concerns strategy,** we committed to managing the concerns we receive in a way that is free from discrimination and bias. Part of this commitment involves taking appropriate action when concerns are raised about discriminatory behaviour by pharmacy professionals and taking relevant external expert advice on such matters where necessary. Additionally, in the strategy, we said that we will support people to make non-discriminatory regulatory decisions.

In our organisational-wide **EDI strategy**, we also committed to making regulatory decisions that are demonstrably fair and free from discrimination and bias.

These strategies are interconnected. They each have a clear focus on how we will minimise and deal with the risk of potential biases in our decision-making and how we will manage concerns about discrimination.

To deliver on our published strategy commitments, we want to strengthen our hearings and outcomes guidance to address how decision makers should consider concerns about discrimination. The strengthened guidance will also look at taking account of cultural factors when professionals are demonstrating insight, for example when expressing an apology. Our aim is to be clear about how seriously concerns of this nature need to be taken and that fitness to practise decision makers should, when deciding on an outcome, take into consideration the seriousness of any discriminatory behaviour.

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 with our proposed changes, or the aspects respondents felt we should modify. 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. Inclusion of discriminatory behaviour section in the guidance

Table 1: Views on whether respondents agree or disagree with the proposed text (Base: All respondents)

Q1. Do you agree or disagree with the proposed text on discriminatory behaviour for inclusion in our guidance?	N and % individuals	N and % organisations	N and % Total
Strongly agree	58 (28%)	4 (36%)	62 (29%)
Agree	95 (47%)	5 (45%)	100 (47%)
Neither agree nor disagree	19 (9%)	- (0%)	19 (9%)
Disagree	11 (5%)	1 (9%)	12 (6%)
Strongly disagree	17 (8%)	1 (9%)	18 (8%)
Don't know	4 (2%)	- (0%)	4 (2%)
Total N and % of responses	**204 (100%)**	**11 (100%)**	**215 (100%)**

Overall, the majority of all respondents (76%) agreed with the proposed text on discriminatory behaviour to be included in the guidance. Those that shared this view included slightly more organisational respondents (81%) than individuals (75%). In contrast, far fewer respondents (14%), a small number of individuals (13%) and organisational respondents (18%), did not agree with the inclusion of the proposed text. A minority of individual respondents (11%) either did not choose their stance on this or did not know whether they agreed or disagreed with the inclusion of the proposed text, whilst 0% of the organisations chose these responses.

Around half of all respondents left explanatory comments to question 1. Set out below is an analysis of the themes found in their responses.

1.1. Summary of themes

Respondents who left comments to this question predominantly held positive views on the need for tackling discriminatory behaviour as it is a serious offence and there should be more awareness in the pharmacy sector. Those who spoke positively about the guidance, explained that it was well-structured, fair and accurate. However, some respondents felt that further clarifications are needed, particularly with additions of examples across all protected characteristics. Nonetheless, some respondents still felt that the proposed hearings and outcomes guidance is too stringent and may lead to restrictions to freedom of speech.

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

- Acts of discrimination are serious and need to be tackled
- Statements included in the proposed text are accurate, fair, and robust
- Further clarifications, definitions and more examples are required in the guidance
- The proposed changes are too stringent
- The proposed text is needed to understand and reflect the diversity within the profession/population
- Restrictions to freedom of speech
- Other groups and circumstances that need to be considered
- Other comments.

1.2. Acts of discrimination are serious and need to be tackled

The most common theme to emerge from this question was that acts of discriminatory behaviour are serious and should be penalised. Respondents who shared this view stated that discrimination exists and needs to be addressed and agreed that there is no place for discrimination in the workplace or in personal settings. Not only did this emerge as crucial for workplace culture but some respondents thought that it should also be strongly embedded in the professional standards of practice.

Most organisational respondents supported this theme. In addition, many individual respondents also thought that providing guidance on the seriousness of discriminatory actions is helpful as those who have never experienced it may not otherwise understand the impact it carries. Some pointed out how discriminatory behaviour is damaging and leaves long-lasting adverse effects which can result in serious harm. Some respondents further emphasised their agreement that any concerns involving discrimination should be considered in the fitness to practise decision-making.

1.3. Statements included in the proposed text are accurate, fair, and robust

Respondents found the inclusion of the proposed text to be accurate, fair, and robust. Many respondents spoke generally about the statements being clear, including appropriate wording and free from ambiguity. Furthermore, the easy-to-comprehend language and accessibility were highlighted as advantageous. The inclusion of examples and references to the protected characteristics were deemed helpful. Overall, the respondents felt that the inclusion of the proposed text goes into greater detail on what is expected from a professional's behaviour and allows for confirmation on what conduct is expected of the pharmacy professionals toward colleagues, patients and members of the public.

1.4. Further clarifications, definitions and more examples are required in the guidance

Many respondents, including a higher proportion of organisational respondents than individuals, put forward suggestions on areas that the guidance could include or could address in more detail.

Commenting on the proposed text, many respondents requested that further clarifications be made. Of particular importance, respondents invited more examples across all the nine protected characteristics. For better practice, some specified further guidance on how to manage situations when treatment or medication and protected characteristics are linked, such as race and hypertension or sex and valproate. Furthermore, others said more examples of other forms of discrimination, not connected to protected characteristics, should also be included in the guidance.

A few respondents were concerned that the proposed text should provide definitions on the terms 'bullying', 'harassment', and 'discrimination' as they are distinct from one another. For further clarity, definition on 'hate speech' was also mentioned. Respondents who shared these views, felt the clear definitions of these terms will allow better understanding of direct and indirect discrimination.

Since discrimination may be seen both inside and outside a professional's working life, some respondents mentioned that it would be helpful to provide examples of how this type of behaviour may be exhibited. For example, additional material of real-life case studies involving discriminatory behaviour to learn from would support pharmacy professionals in their daily practice. Some respondents were also concerned with clarity of what is acceptable to engage with online.

Although the examples in the guidance were welcomed by many respondents, a small number also felt that they could be revised or tweaked further to maximise their benefit. On this, a small number of respondents disagreed with the wording of the proposed text, specifically the word 'aggravating'. Some respondents also noticed terminology inaccuracies that need to be updated or amended.

1.5. The proposed changes are too stringent

Another common theme amongst organisational respondents was that as the proposed text currently stands, the guidance may be too stringent. Explaining this view further, respondents agreed that the guidance should stress the inherent seriousness of discriminatory behaviour, nonetheless they showed concern as to why the conduct should always sit at the upper end of the scale, i.e., impairment and sanction stages. Those who shared this view, invited more discretion for the panel in making decisions when faced with a case based on discrimination. Some suggested that this should be reviewed and decided on a case-by-case basis for when there may be shades of grey. Thus, it has been stressed that the guidance should allow the committee to determine the appropriate sanction or a mitigation on a case-by-case basis within a wider scope of outcomes.

Moreover, other examples of mitigating factors were discussed including the presence or absence of police investigation of racially motivated comments on social media, consideration of historic comments, or young age of the registrant who since has had time to change their views.

A few individual respondents shared the view of organisations that the panel should have the freedom to consider the concern within its context, the motivations behind it and any patterns of behaviour before deciding on the appropriate sanction.

1.6. The proposed text is needed to understand and reflect the diversity within the profession/population

Many respondents held a positive view on the inclusion of the proposed text. 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 pharmacy. Most of these respondents emphasised that the proposed text would foster a mutual understanding and reflect the diversity within British society. Those who shared this view, further highlighted that treating people fairly, regardless of their race, sex, age or beliefs is essential for pharmacy professionals to provide effective care and maintain trust with their patients and colleagues. At a minimum, a few respondents thought that acknowledging the diversity within the profession will encourage the responsibility of health professionals to gain personal insight and address any biases.

1.7. Restrictions to freedom of speech

Disagreeing with the proposed text, some individual respondents stated that expressing views in private or on social media should not be considered in the fitness to practise process. This theme was not present amongst organisational respondents. Those individuals who shared this view often referred to restrictions to freedom of speech or that private conversations may be taken out of context and considered an offence. A small number of respondents who felt neutral about the inclusion of discriminatory behaviour in the hearings and outcomes guidance, commented that a reasonable public discussion should be allowed, and that the proposed text will otherwise stifle debate. One respondent emphasised that individuals who do not share any protected characteristics should not be afraid to speak out against colleagues who share protected characteristics if discriminatory behaviour takes place.

1.8. Other groups and circumstances that need to be considered

In addition to the themes highlighted above, some organisations and a few individual respondents provided comments on specific groups or circumstances that should be considered to improve the guidance.

Though this theme was more prevalent among organisational responses, some individuals implied certain circumstances that should be accounted for based on their personal experiences. Specifically, respondents observed that:

- Greater consideration should be given around mental health issues
- Many individual respondents shared the view of female pharmacists being harassed or discriminated against in the workplace and how this should be addressed in the guidance. Some called for more support for female pharmacists
- Nationality has been highlighted as an important characteristic that is often overlooked and individual respondents pointed out that it is common to be discriminated against based on nationality alone
- Age (and ageism) was another factor that respondents believed to affect the use of language in everyday work
- Some individual respondents pointed out that pharmacy professionals are also often discriminated against by patients and such circumstances should be included in the proposed text

- Lastly, many respondents felt that there is too much emphasis put on race and religion, and that all individuals should be covered under the proposed text not just minorities

Furthermore, organisational respondents drew attention to non-verbal cues such as eye contact, facial expressions or gestures and pointed out sexism or ableism as unacceptable forms of discrimination to ensure an intersectional perspective is being considered. Whilst some organisations questioned the risk of creating an impression of a hierarchy of some protected characteristics listed, one organisation drew attention to disability to be more emphasised in the guidance.

1.9. Other comments

Respondents raised a number of other points not already mentioned which are captured below, in order of frequency:

- Some respondents warned that institutionalised racism and bullying exists and that those in authority abuse their positions and rarely face consequences. Additionally, that the guidance should also cover discrimination in recruitment processes.
- Respondents put forward a number of suggestions or areas that they felt were missing or required more detail in the guidance. These included the importance of implementing Equality, Diversity and Inclusion training in the workplace, particularly in relation to microaggression and how to approach gender pronouns.
- A couple of respondents felt that the proposed text implies GPhC fitness to practise processing to be above law, particularly when something may be considered legal but is penalised by the GPhC.
- It was noted by a respondent that historical social media activity should not necessarily be considered as people improve their understanding of discriminatory behaviour and language.
- Another respondent commented that the proposed text is too lengthy and too complex.
- One organisation said that the language used in the guidance should be adjusted to remain balanced and fair.

2. Inclusion of cultural factors in insight, remediation, and testimonials in the guidance

Table 2: Views on whether respondents agree or disagree with the proposed text (Base: All respondents)

Q2. Do you agree or disagree with the proposed text on cultural factors in insight, remediation, and testimonials for inclusion in the guidance?	N and % individuals	N and % organisations	N and % Total
Strongly agree	43 (21%)	1 (9%)	44 (20%)
Agree	92 (45%)	7 (64%)	99 (46%)
Neither agree nor disagree	29 (14%)	1 (9%)	30 (14%)
Disagree	16 (8%)	1 (9%)	17 (8%)

Q2. Do you agree or disagree with the proposed text on cultural factors in insight, remediation, and testimonials for inclusion in the guidance?	N and % individuals	N and % organisations	N and % Total
Strongly disagree	20 (10%)	1 (9%)	21 (10%)
Don't know	4 (2%)	- (0%)	4 (2%)
Total N and % of responses	**204 (100%)**	**11 (100%)**	**215 (100%)**

Overall, most respondents (66%) agreed with the proposed text on cultural factors in insight, remediation and testimonials to be included in the guidance. Those that shared this view included slightly more organisational respondents (73%) than individuals (66%). In contrast, a modest proportion of all respondents (18%) including the same percentage of individuals (18%) and organisational respondents (18%), did not agree with the inclusion of the proposed text. A smaller percentage of individual respondents (16%) neither agreed nor disagreed, and this view was also shared by 9% of organisational respondents. Only 2% of individuals did not know whether we should include the proposed text, whilst 0% of the organisations chose this response.

Around half of all respondents left explanatory comments to question 2. Set out below is an analysis of the themes found in their responses.

2.1. Summary of themes

Respondents who left comments on this question held mixed views about the proposed text. The majority agreed that there are differences across cultures, and these should not be ignored at hearings. However, many respondents still sought more information on the implementation of the proposed changes. Those in opposition were worried that the guidance is too stringent with sanctions at the upper end of the scale. Additionally, some respondents felt that cultural factors should not be considered at all in the fitness to practise processes.

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

- There are differences across cultures
- More information is required on implementing the guidance
- The proposed text is needed to understand and reflect the diversity within the profession/ population
- The proposed changes are too stringent
- Cultural factors should not be considered
- Other comments

2.2. There are differences across cultures

The most common theme to emerge to this question, was that differences across cultures, including different communication styles exist and should be considered. In support of the proposed text on cultural factors in insight, remediation and testimonials, respondents agreed that acknowledging

differences across cultures, communication and languages is encouraging; as this will further help remove bias and discrimination, as well as stereotyping minorities.

When talking about cultural differences, respondents often referred to communication being different across cultures. Respondents highlighted an overlap between cultural factors affecting meaning and on how people communicate. Furthermore, some pointed out that English not being a native language may be misinterpreted or miscommunicated during a hearing.

Overall, this theme was more prevalent among organisational respondents. Individual and organisational respondents shared a similar view whereby they provided examples of how individuals communicate or express themselves may affect an apology or expression of regret by how it is framed or delivered. Some mentioned that it can take many years before one is truly comfortable in a language that isn't their mother tongue. Moreover, some organisations pointed out that there needs to be an understanding that for some cultures presenting written apologies is not a norm.

2.3. More information is required on implementing the guidance

Half of the organisational respondents and a small number of individuals 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 by providing more detail on:

- How committee members will be supported to enhance their understanding of differences in cultural behaviours and attitudes
- Whether there will be a formal requirement to ensure all committees are composed of panel members from different cultural backgrounds
- Whether there will be a requirement to have a member of the panel from a similar cultural background to the registrant
- How the panel will keep their knowledge up to date with changes in cultural behaviours and values
- How will the committee approach cases involving discrimination resulting from a clash of cultural values
- And how will the GPhC ensure a consistent and fair approach is achieved

A few organisations had reservations about the proposed text, particularly as to what encompasses cultural factors and that there may be a potential for incorrect removal (from the register) due to these factors. Moreover, clarity on whether this would relate to all protected characteristics, or certain ones that involve cultural factors such as ethnicity and religion, should be provided as other aspects of a person's cultural background such as their socioeconomic roots may also be relevant.

2.4. The proposed text is needed to understand and reflect the diversity within the profession/population

Agreeing with the proposed text, a few respondents again highlighted the importance of GPhC adopting a holistic approach by taking cultural factors into account. Further, respondents emphasised that as a multiracial nation, there must be a consideration for anything that may get lost in translation including nonverbal cues that may be culturally dependent. Moreover, it has been pointed out that as

professionals, pharmacists should be aware of cultural factors in their work and the language and behaviour they display must be appropriate and show understanding of individual needs.

A small number of organisations further highlighted that cultural and religious backgrounds should be considered and an understanding is needed for learned attitudes that may be different to British social norms. Please refer to section 1.6 for further detail on this theme.

2.5. The proposed changes are too stringent

Similarly, to section 1.5 above, a few organisational respondents and a handful of individual respondents shared their views about the severity of the sanctions. Under question 2, a few individual respondents said that the GPhC should educate and not punish pharmacy professionals on the grounds of cultural misbehaviour. Those individuals said they found the current text to be unfair and argued that everyone deserves a second chance, particularly in cases where remorse is demonstrated and there is evidence for remedial action.

Additionally, organisational respondents expressed further that there should be provision for the committee to determine the appropriate sanction (if at all) on a case-by-case basis with a regular review to ensure the reliability of the guidance.

2.6. Cultural factors should not be considered

Disagreeing with the proposed text, a theme amongst individual respondents was that culture should not make a difference, should not be considered in the fitness to practise processes and that every culture should be treated the same. Of the respondents who shared this view, some argued that GPhC should be culturally neutral, as otherwise, the process may be unfair towards some cultures more than others. Others argued that empathy, compassion and showing remorse are culturally neutral and good communication is required to practise. A smaller number of respondents said that cultural factors should be 'no excuse' for poor practice.

In comparison, none of the organisational respondents shared this view.

2.7. Other comments

Alongside the themes already explored in this section, individual respondents raised a number of other points which are captured below, in order of frequency:

- Respondents put forward a few suggestions or areas that they felt were either missing or required more consideration in the guidance. For example, regarding apologies, some respondents said that the same cultural consideration should be given to the complainant as well as the registrant or that many NHS and GPhC standards refer to the requirement to apologise during fitness to practise processes.
- Some respondents pointed out that education on cultural differences in communication is required from the university level onwards.
- Others said that the reasons behind an action, the potential for repetition of behaviour and whether any lessons have been learned should all be taken into account in the decision-making.
- One respondent pointed out the issue regarding the lack of testimonials is relevant to all going through fitness to practise processes, not just minorities.

3. The impact of the proposed changes on people sharing protected characteristics

Table 3: Views on the impact of the proposed text on people sharing protected characteristics (Base: All respondents)

Q3. Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the protected characteristics?	N and % individuals	N and % organisations	N and % Total
Yes – positive impact	103 (28%)	7 (64%)	110 (51%)
Yes – both positive and negative impact	43 (47%)	2 (18%)	45 (21%)
Yes – negative impact	14 (9%)	- (0%)	14 (7%)
No impact	15 (5%)	- (0%)	15 (7%)
Don't know	29 (14%)	2 (18%)	31 (14%)
Total N and % of responses	**204 (100%)**	**11 (100%)**	**215 (100%)**

Table 3 shows that most of the respondents (51%) felt that our proposed texts on discriminatory behaviour and cultural factors in insight, remediation and testimonials would have a positive impact on groups or individuals who share any of the nine protected characteristics under the Equality Act 2010.

A moderate proportion of individuals (21%) and organisations (18%) felt that the inclusion of the proposed texts would have both positive and negative impact. Only a small number of individuals (7%) thought this would have a negative impact, or no impact at all on groups or individuals who share protected characteristics, whilst no organisation shared this view.

A similar proportion of organisations (18%) and individuals (14%) did not know what the impact of the proposed texts would be.

Around one third of all respondents left explanatory comments to question 3. Set out below is an analysis of the themes found in their responses.

3.1. Summary of themes

Respondents shared mixed views in the comments on the impact question. Many respondents held positive views on the impact of the proposed changes to the guidance, particularly for those who share protected characteristics and that this should increase people's confidence in raising concerns on the grounds of discrimination and racism. On the other hand, some respondents felt that the proposed texts need to be improved by adding more examples of groups and circumstances that need to be taken into account for a more holistic approach. A handful of respondents held reservations as to the impact and need of the proposed changes in general.

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

- Positive impact on people who share protected characteristics

- More information required on implementing the guidance
- Other groups and circumstances that need to be considered
- Further clarifications, definitions and more examples required in the guidance
- General negative view on the proposed texts
- The proposed texts are needed to understand and reflect the diversity within the profession/population
- Other comments

3.2. Positive impact on people who share protected characteristics

A majority of organisational and a high proportion of individual respondents said that the proposed changes will have a positive impact on people who share protected characteristics. Explaining further, these respondents felt that the inclusion of the proposed texts will make processes fairer. Many respondents stressed that individuals or groups that are considered a minority will be positively impacted, hoping that this will give people confidence to report unacceptable behaviour with the knowledge that there is a clear process in place to deal with it.

Furthermore, respondents said that the proposed changes should reassure the public, especially those at risk of discrimination on the grounds of protected characteristics, that the GPhC aims to protect them. Overall, groups such as members of the public, patients and pharmacy professionals who have been discriminated against were also mentioned to be positively impacted.

3.3. More information required on implementing the guidance

A half of organisations brought up the importance of clear guidance and detailed prognosis of current baselines, targets and how success will be measured to understand the impact of the guidance on discrimination in fitness to practise hearings. All those organisational respondents thought that there will be a positive impact on individuals or groups who share protected characteristics, and the process should be fair as long as committee members can understand how these characteristics affect how an individual or a group deal with a particular situation. For more detail around this theme, please refer to section 2.3.

3.4. Other groups and circumstances that need to be considered

Another theme shared by a smaller number of respondents was that when assessing the impact of the guidance, there are other groups and circumstances that need to be considered.

This theme was apparent in respondents who presented a mixture of positive and negative views on the impact the guidance will have on individuals sharing protected characteristics. Examples given included non-verbal cues such as eye contact, facial expressions or gestures that need to be noted in the proposed guidance, circumstances such as sight impairment which may result in difficulty making eye contact with committee members, and the need for the committee to be aware and sensitive to the many issues that could amount to demonstration of insight and remorse.

There was a shared view among some of the organisational respondents that the examples provided in the proposed guidance are at risk of creating an impression of hierarchy. These respondents stressed that the visible focus on race and ethnicity in particular, may overshadow disadvantages individuals with disability face. For example, for a wider positive impact, neurodiversity should be included to further

emphasise how remorse may be communicated by pharmacy professionals with this protected characteristic.

Please refer to section 1.8 for further examples.

3.5. Further clarifications, definitions and more examples required in the guidance

Whilst examples on race and religion were provided in the guidance, a few organisations further emphasised the need for a wider number of examples for each protected characteristic. Whilst most respondents agreed that the proposed changes will have a positive impact on individuals or groups sharing protected characteristics, some pointed to a couple of examples where this may not be the case. For example, when a clinical decision is based on age, under the guidance this may be viewed as discriminatory. However, age may be a necessitating factor in that clinical decision and would therefore be justified. Another protected characteristic where there may be a negative impact is gender reassignment, particularly in instances relating to prescribing/dispensing medication such as hormone blockers for children and young people. In addition, and more broadly, the importance of not discriminating against transgender patients seeking pharmacy services and ensuring they do not receive a lower standard of care could be made explicit.

3.6. General negative about the proposed texts

This theme collated a spectrum of negative views put forward by a minority of individual respondents, and no organisations. Some respondents emphasised their overall negative attitude towards the proposed changes by suggesting that it is time wasting or unnecessary to implement them. A small number of respondents highlighted their opinion that White British are also discriminated against and showed general disagreement with the focus on Equality, Diversity and Inclusion in the hearings and outcomes guidance discussion paper.

Some individuals said that they believe there will be no impact after the inclusion of proposed texts on those sharing protected characteristics.

3.7. The proposed texts are needed to understand and reflect the diversity within the profession/population

Echoing points made to the previous two questions, respondents said that they are striving to see a fair and proportionate treatment of all people, and that they think the proposed changes will result in positive impact for all. For a more detailed passage, please refer to sections 1.6 and 2.4.

3.8. Other comments

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

- Some individual respondents and one organisation commented that there is generally a negative impact on mental health in fitness to practise process as some ethnicities may not receive support from family or friends due to it being a taboo subject. This lack of support, and as a result an adverse effect on mental health, could also apply to pharmacists from overseas.
- Another comment around mental health suggested an assessment should be conducted to identify whether support is needed.
- A respondent highlighted that the guidance should have an impact not only at a group level but also at an individual level.

- Lastly, there was a concern raised that individuals who do not share protected characteristics will be treated more harshly once the proposed texts are implemented.

Appendix 1: Summary of our proposals

Strengthening the guidance will guide fitness to practise committees on concerns that involve discrimination, and how to consider some aspects when there are cultural sensitivities. The following section sets out how we propose to strengthen the guidance across two areas:

- part one: supporting decision making in hearings where discrimination is a factor
- part two: taking account of cultural factors when panels are deciding on an outcome

We are also making a number of other changes to the guidance. This includes a changes to the language to improve consistency with similar decision-making guidance, and the title of the document to 'hearings and outcomes guidance' to better reflect the content and terminology we use. These changes were not part of this discussion paper as they were minor changes.

Supporting decision making in hearings where discrimination is a factor

Discriminatory behaviour of any kind can negatively affect public safety and confidence in the profession. Professionals should be aware of how their behaviour can affect and influence the behaviour of others and affect the ability to provide patient care. The environment that pharmacy and other health and social care professionals work in should be safe and free from discriminatory behaviour.

We are proposing to include the following text for committees to take account of when making a decision on the appropriate outcome:

"Discriminatory behaviour and attitudes undermine public confidence and trust in the pharmacy professions and can have an impact on the reputation of professionals. Our standards state that we expect professionals to recognise and value diversity, and respect cultural differences making sure that every person is treated fairly whatever their values and beliefs. This is essential for professionals to provide safe care and maintain trust with their patients and colleagues.

All forms of discriminatory behaviour on the part of professionals towards patients, the public and colleagues are unacceptable in society. We take all concerns relating to this seriously. Discriminatory behaviour can include:

- abusive verbal comments, including hate speech, or offensive writing towards someone because of their protected characteristics such as their race, sex and gender, religion or sexuality
- threatening or aggressive behaviour towards someone because of their race, sex and gender, religion, sexuality or other protected characteristics
- comments on social media or public platforms about a particular group of people because of their protected characteristics
- refusing a patient treatment based on the patient's protected characteristics
- treating a patient less favourably because of a protected characteristic
- treating a colleague less favourably because of their protected characteristics

Discriminatory behaviour can happen in various settings including at a professional's place of work when interacting with patients or colleagues, in their personal life or in a wider social setting. The committee should consider the circumstances in which the behaviour took place. This is so it can decide if there are

any wider implications in maintaining public confidence in the profession. The committee should also consider any cautions or convictions as a result of the professional's actions, and any implications this may have on their fitness to practise and the wider pharmacy profession.

When deciding on an outcome, the committee should balance all the relevant issues, including any aggravating and mitigating factors. Because of the serious nature of these concerns and the impact on public trust and confidence in the profession, the committee should consider outcomes at the upper end of the scale."

Taking account of cultural factors when panels are deciding on an outcome

Committees must make sure they have the fullest possible evidence before they reach a decision. Their determination should reflect their decision-making process and demonstrate that they considered the context. When a committee makes a decision about a pharmacy professional's fitness to practise, and the appropriate outcome, it must:

- take into account the context and circumstances of a case, and
- carefully consider all the evidence that is presented to it, including any aggravating or mitigating factors

Aggravating factors are the circumstances of the case that make what happened more serious – for example, persistent behaviour and abuse of a position of trust. Mitigating factors are the opposite of this. They may include, for example:

- evidence of insight and understanding
- meeting the requirements of core professional standards
- testimonials, and
- expressions of apology

We are proposing the inclusion of the following text for committees to take account of when deciding on the appropriate outcome.

Insight and remediation

When deciding what action to take, decision makers must consider:

- the nature of the concern
- whether the actions can be remediated, and
- if a professional can demonstrate insight

There may be some cases where a professional's conduct is so serious that it is not remediable. This means that even though the professional may provide evidence of insight and remediation, the conduct is so serious that it is not appropriate to take this evidence into account when considering an outcome. Examples where this may occur include concerns involving discriminatory behaviour or sexual misconduct. This is because regulatory action is necessary to ensure public protection and maintain public confidence in pharmacy, and a professional's involvement in these matters can undermine this.

The committee should be aware that there may be cultural differences or a professional's personal circumstances, such as ill-health, that may affect the way an individual communicates and expresses themselves. This could affect, for example, how an apology, insight or expression of regret is framed and

delivered. This is particularly the case for individuals who are communicating in a second language and may use elements of their first language to construct their sentences or statements. This could alter the intended meaning when spoken in their second language. Expressions of apology, and how an apology is communicated, can differ across cultures, and be affected by religion and beliefs. For example, in some cultures written apologies are not the norm.

There may also be differences in the way individuals use non-verbal cues to communicate. This will include, among other things, facial expressions, eye contact and gestures. For example, a professional with a sight impairment may have difficulty making eye contact with committee members. The committee should be aware of and sensitive to these issues when deciding how a professional frames their insight and remorse, and in judging their behaviour and attitude during the hearing.

Testimonials

The committee should be aware that in some circumstances, there may be cultural or other reasons why a professional may not want to ask for testimonials (or references). For example, sharing information about their investigation with family members or colleagues may affect their private lives, and their reputation with their family and community. The committee should bear this in mind and not make assumptions about why there is an absence of this type of evidence. Equally the committee should not speculate as to what may have been said had any references or testimonials been requested."

Appendix 2: About the consultation

Overview

The consultation was open for 9 weeks, beginning on 29 November 2022 and ending on 31 January 2023. 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 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.

Survey

We received a total of **218** written responses to our consultation. **204** of these respondents identified themselves as individuals and **14** responded on behalf of an organisation.

Of these responses, **215** had responded to the consultation survey (**204** individuals and **11** organisations). Most 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.

Alongside these, we received **3** responses from organisations writing more generally about their views.

Social media

We monitored social media activity during the consultation period and in this instance, there was no additional 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 represent fairly the wide range of views put forward, whether they have been presented by individuals or organisations, and whether we have received them in writing.

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 and those who emailed their responses to the consultation questions. 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.

The consultation questions are provided in **Appendix 6**.

Quantitative analysis

The survey contained a number of 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. Those responding by post or email more generally about their views are captured under the qualitative analysis only.

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 5) of multiple responses were received from the same individuals. These were identified by matching 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%. This rounding also results in differences of up to one percentage point when combining two or more response categories. 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.

Cells with no data are marked with a dash.

Qualitative analysis

This analysis report includes a qualitative analysis of all responses to the consultation, including online survey responses from individuals and organisations and email 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 or pharmacy technicians, 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 1: Responding as an individual or on behalf of an organisation (Base: All respondents)

Are you responding:	Total N	Total %
As an individual	204	95%
On behalf of an organisation	11	5%
Total N and % of responses	**215**	**100%**

Profile of individual respondents

Table 2: Countries (Base: All individuals)

Where do you live?	Total N	Total %
England	178	87%
Scotland	15	7%
Wales	8	4%
Northern Ireland	-	0%
Other	3	1%
Total N and % of responses	**204**	**100%**

Table 3: Respondent type (Base: All individuals)

Are you responding as:	Total N	Total %
A pharmacist	164	80%
A pharmacy technician	35	17%
A legal professional	-	0%
A member of the public	4	2%
Other	1	0%
Total N and % of responses	**204**	**100%**

Table 4: Main area of work (Base: Individuals excluding members of the public)

Sector	Total N	Total %
Community pharmacy (including online)	88	44%
Hospital pharmacy	48	24%
GP practice	21	11%
Primary care organisation	16	8%
Research, education or training	10	5%
Pharmaceutical industry	1	1%
Prison pharmacy	1	1%
Other	15	8%
Total N and % of responses	**200**	**100%**

Table 5: Size of community pharmacy (Base: Individuals working in community pharmacy)

Size of pharmacy chain	Total N	Total %
Independent pharmacy (1 pharmacy)	18	20%
Independent pharmacy chain (2-5 pharmacies)	13	15%
Small multiple pharmacy chain (6-25 pharmacies)	6	7%
Medium multiple pharmacy chain (26-100 pharmacies)	7	8%
Large multiple pharmacy chain (Over 100 pharmacies)	44	50%
Total N and % of responses	**88**	**100%**

Table 6: History of being involved in GPhC's fitness to practise processes (Base: All individuals)

Size of pharmacy chain	Total N	Total %
Yes	31	15%
No	161	79%
Prefer not to say	8	4%
Don't know	4	2%
Total N and % of responses	**204**	**100%**

Profile of organisational respondents

Table 1: Type of organisation (Base: All organisations)

Is your organisation:	Total N	Total %
Organisation representing pharmacy professionals	5	45%
Registered pharmacy	2	18%
Regulatory body	1	9%
Other	3	27%
Total N and % of responses	**11**	**100%**

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.

Appendix 5: Organisations

The following organisations engaged in the consultation through the online survey and email responses:

APTUK

Boots

Community Pharmacy Scotland

Community Pharmacy Wales (CPW)

Company Chemists Association

General Medical Council (GMC)

NHS Greater Glasgow and Clyde Area Pharmaceutical Committee

NPA

Pharmacist Support

Pharmacists' Defence Association (PDA)

Pharmacy Law & Ethics Association

Professional Standards Authority (PSA)

Rowlands Pharmacy

Royal Pharmaceutical Society (RPS)

Appendix 6: Consultation questions

Section one: Supporting decision making in hearings where discrimination is a factor. We are proposing to include the paragraphs outlined earlier in this document, and included from section 6.14 in the full guidance document in the appendix. These set out our position on how serious concerns involving discrimination are and will support decision making.

1. Do you agree or disagree with the proposed text on discriminatory behaviour for inclusion in our guidance?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Don't know

Please explain your answer.

Section two: Taking account of cultural factors when panels are deciding on an outcome. We are proposing to include the paragraphs outlined earlier in this document, and included from section 5.20 in the full guidance document in the appendix. This will support committee decision making and will help to make sure their decisions are fair and free from discrimination and bias.

2. Do you agree or disagree with the proposed text on cultural factors in insight, remorse, and testimonials for inclusion in the guidance?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Don't know

Please explain your answer.
We want to understand whether our proposals may have a positive or negative impact on individuals or groups sharing any of the protected characteristics in the Equality Act 2010. The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race/ethnicity
- religion or belief

- sex
- sexual orientation

3. Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the protected characteristics?

Yes – positive impact
Yes – negative impact
Yes – both positive and negative impact
No impact
Don't know

Do you have any other comments about the impact of the proposals on individuals or groups sharing protected characteristics?

Good decision making: fitness to practise hearings and outcomes guidance

Revised ~~September~~ December 2023

Contents

About us

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacy premises in England, Scotland and Wales. It is our job to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.

Our main work includes:

- setting standards for the education and training of pharmacists and pharmacy technicians, and approving and accrediting their qualifications and training
- maintaining a register of pharmacists, pharmacy technicians and pharmacies
- setting the standards that pharmacy professionals have to meet throughout their careers
- investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public
- setting standards for registered pharmacies which require them to provide a safe and effective service to patients
- inspecting registered pharmacies to check if they are meeting our standards

We are committed to protecting, promoting and improving the health and safety of people who use pharmacy services in England, Scotland and Wales. An important part of that role is dealing with the small number of pharmacists and pharmacy technicians who fall short of the standards that the public can reasonably expect from healthcare professionals.

1 Introduction

What this guidance is about

1.1 This guidance tells you about our fitness to practise hearings, how decisions are made and the outcomes which committees can decide on. It also provides guidance for committees to use when deciding what outcome is appropriate in any given case.

1.2 This guidance is in two parts:

Part a: Hearings and the decision-making process

This part tells you about fitness to practise hearings, how they fit into the decision-making process and how a committee reaches a decision about which outcome is appropriate. It will support understanding of how the committee reaches a decision and what the ~~outcomes are.~~different stages are ~~It also contains guidance on hearings (part a), including what happens at a hearing,~~ to make sure that all parties are aware from the outset of the approach that the committee will take when deciding on an outcome.

Part b: Guidance on outcomes

This part sets out the GPhC's guidance on what outcomes are, and what issues or factors a committee should consider before deciding on an outcome. It will support consistent and proportionate committee decision making.

1.3 ~~This guidance, particularly part~~Part B ~~b, is~~ of the guidance ~~for use~~will be used primarily by those involved in hearings particularly ~~b~~by fitness to practise committees ~~at a hearing~~ when considering what outcome is appropriate following a finding that a pharmacy professional's fitness to practise is impaired. It outlines the purpose of the available outcomes and the factors to be considered when making a decision. ~~It also contains guidance on hearings (part a), including what happens at a hearing, to make sure that all parties are aware from the outset of the approach that the committee will take when deciding on an outcome.~~

Who this guidance is for

1.4 This guidance is aimed at everyone who is involved in a fitness to practise hearing. This includes GPhC staff, committee members, pharmacy professionals (whether appearing at a hearing or not) and their representatives. It will also be useful to anyone who is interested in a fitness to practise hearing, including:

- patients and members of the public thinking about raising a concern with the GPhC about a professional
- patients and members of the public who have raised a concern with the GPhC about a professional
- patients and their representatives
- defence organisations
- other regulatory bodies, including the Professional Standards Authority (PSA)
- the courts

1.5 We will regularly review this guidance to:

- take account of changes to legislation and case law
- make sure it stays ‘fit for purpose’ and accessible to all stakeholders

Equality and diversity

1.6 The GPhC is committed to delivering equality, improving diversity and fostering inclusion when it does its work. We value diversity and individuality in our workforce (including our decision-makers), the public and the professionals we regulate. Our processes are designed to be fair, objective, transparent and free from discrimination, and that all stakeholders receive a high level of service. We keep to the principles set out in the Equality Act 2010 and our equality, diversity and inclusion (EDI) strategy and approach.

1.7 All of our workforce is expected to demonstrate our values and to apply these at all times during the fitness to practise process. The GPhC upholds and follows the principles of the European Convention on Human Rights (ECHR) in line with the Human Rights Act 1998.

Part a: Hearings and the decision-making process

This part tells you about fitness to practise hearings, how they fit into the decision-making process and how a committee reaches a decision about which outcome is appropriate.

2 Hearings

2.1 A fitness to practise hearing is one potential outcome and part of a detailed process that begins when we receive a concern about a professional's fitness to practise[1]. This process can end at several key stages:

- after an initial assessment of the concern
- after an investigation takes place
- at an investigating committee meeting
- at a fitness to practise committee hearing[2]

The guidance used at each stage of the process

2.2 Decision-making guidance is used at each stage to decide what action to take.

Our **threshold criteria** are used at the investigation stage to decide whether to refer a case to the investigating committee.

Our ***Good decision making: investigating committee meetings and outcomes guidance***[3] is used by the investigating committee to help it deal with cases it makes a decision on.

This guidance covers fitness to practise hearings and the decisions made by a fitness to practise committee during a hearing.

2.3 If a case is referred to the fitness to practise committee, there will usually be a hearing. The hearing is held by a panel of three people (a chair, a professional member and a lay member).

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[1] If the allegation is one that the GPhC can deal with

[2] Some cases are referred directly by the Registrar under Article 52 (2) (b) and Article 54 (1) (a) of The Pharmacy Order 2010

[3] **www.pharmacyregulation.org/content/good-decision-making-investigating-committee-meetings-and-outcomes-guidance-0**

2.4 Other people may also be at the hearing, including a legal adviser, a medical adviser, GPhC staff and professionals' representatives. However, some professionals may attend a hearing without a representative. In these circumstances, the committee chair should make sure that a brief explanation of the hearing process, including the roles of the various people at the hearing and the different stages of the hearing, is given before the hearing begins. The committee chair will also check if the professional has any particular needs, concerns or vulnerabilities which might affect their ability to take part in the hearing.

2.5 Committees hear evidence and decide whether a professional's fitness to practise is impaired[4]. The fitness to practise committee is independent of the GPhC. It is accountable[5] for the decisions it makes and must take account of guidance produced by the GPhC[6].

2.6 In most cases, a committee will hold a hearing in public. But a hearing may be held wholly or partly in private if the committee is satisfied that the interests of the professional concerned, or of a third party, in maintaining their privacy outweigh the public interest in holding the hearing, or that part of the hearing, in public[7]. If the hearing is about the health of the professional, or relates to an interim order, the committee must hold it in private. However, if it is satisfied that the interests of the professional concerned, or of a third party, in maintaining their privacy are outweighed by the public interest it may hold the hearing in public[8].

Reaching a decision

2.7 During a hearing the committee follows a three-stage process before it reaches a decision on which outcome is appropriate[9]. Once the committee has heard the evidence, it must decide:

- whether the **facts** alleged have been found proved
- whether the professional's fitness to practise is **impaired**
- whether any **action** should be taken against the professional's registration or not. This is dealt with in detail in part b of this guidance.

2.8 While coming to its decisions the committee should also keep in mind the overall objectives of the GPhC[10].

Fact finding

2.9 In a hearing, the GPhC has to prove the facts alleged against a professional. The standard of proof which applies is the 'balance of probabilities'. This means that the committee will find an alleged fact 'proved' if it decides, after hearing the evidence, that it is more likely to have happened than not happened. This is not the same as the standard of proof in a criminal court, which is 'so that you are sure'.

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[4] The meaning of impairment is given in paragraph 2.12

[5] All decisions are scrutinised by the Professional Standards Authority and may also be appealed against – see section 29 of the National Health Service Reform and Health Care Professions Act 2002

[6] Rule 31 (14) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[7] Rule 39 – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[8] Rule 39 – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[9] Rule 31 – General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[10] Article 6 - The Pharmacy Order 2010

2.10 If a professional admits any of the facts alleged, the committee must find the admitted facts to be proved[11].

2.11 If the facts alleged against the professional have been proved it does not necessarily mean that there will be a finding of impairment. A committee's decision on impairment must be separate from the decision on the facts of the case. For example, even if there is a finding of misconduct, a committee may decide that a professional's fitness to practise is not impaired and may conclude that no action is needed.

Impairment

2.12 A pharmacy professional is 'fit to practise' when they have the skills, knowledge, character, behaviour and health needed to work as a pharmacist or pharmacy technician safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and also keeping to the principles of good practice set out in our various standards, guidance and advice.

2.13 Fitness to practise can be impaired for a number of reasons. These include misconduct, lack of competence, not having the necessary knowledge of English, ill-health or a conviction for a criminal offence[12].

2.14 The committee may consider allegations about a professional's personal or professional life. They must decide whether the professional's fitness to practise is currently impaired, **not** whether it was at the time the incident happened[13]. The committee must keep in mind the overall objectives of the GPhC when deciding whether a pharmacy professional's fitness to practise is impaired[14]. The committee must also take into account relevant factors, which include whether or not the conduct or behaviour[15]:

- presents an actual or potential risk to patients or to the public
- has brought, or might bring, the profession of pharmacy into disrepute
- has breached one of the fundamental principles of the profession of pharmacy
- shows that the integrity of the professional can no longer be relied upon

2.15 The committee should also consider whether:

- the conduct which led to the concern is able to be addressed
- the conduct which led to the concern has been addressed
- the conduct which led to the concern is likely to be repeated
- a finding of impairment is needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession

[11] Rule 31 (6) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[12] Article 51 – The Pharmacy Order 2010

[13] Meadow v GMC [2007]

[14] Schedule 1(5) (8) – The Pharmacy Order 2010

[15] Rule 5 – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

2.16 In deciding whether a person's fitness to practise is impaired because they do not have the necessary knowledge of English, the committee may take into account, among other things[16]:

- whether the person concerned has not complied with a direction, given under the rules, to have an examination or other assessment of their knowledge of English, or
- whether the person concerned has not provided the registrar with evidence of the result of that examination or assessment

2.17 The decision on impairment is a matter for the judgement of the committee. The committee has to make its own decision about impairment even when it is admitted by the professional. It should make clear what factors it has taken into account when deciding on impairment.

Action taken

2.18 If a committee decides a professional's fitness to practise is impaired, it can:

- take no action
- agree undertakings[17]
- issue a warning
- impose conditions on the professional's practice
- suspend the professional from practising, or
- remove the professional from the register in the most serious cases

2.19 The committee must, having taken account of this guidance, consider the appropriate outcome in the given case, announce its decision and give its reasons for that decision[18].

2.20 These outcomes are intended to protect the public, and the wider public interest, not to punish the professional. You will find more details on these outcomes, and what a committee considers when reaching a decision about a particular outcome, in part b of this document.

The determination

2.21 Once a committee has made a decision at each stage of the hearing, it will give its written 'determination'. The determination is the formal statement by the committee announcing its decision and explaining the reasons for it. The amount of detail a committee gives in a determination depends on the nature and complexity of the case. In every case the reasons should be adequate so that the decision can be easily understood by the professional, the GPhC, the complainant and any other interested party. It should be clear why a particular decision has been made.

2.22 The committee should make sure that the decision on the outcome is fully explained and understood. The written determination should carefully explain, in clear and direct language which leaves no room for misunderstanding or ambiguity:

- what outcome the committee has decided on

[16] Rule 24 (11a) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[17] See paragraph 4.11

[18] Rule 31 (14) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

- the reasons for the outcome, and
- why the committee is satisfied that the decision is sufficient to protect the public. This involves considering the committee's need to protect the health, safety and wellbeing of the public, to maintain public confidence in pharmacy, and to maintain proper professional standards and conduct for pharmacy professionals

2.23 A committee must consider this guidance when reaching a decision on the outcome. If it decides not to take account of the guidance it will be expected to clearly explain its reason for not doing so.

2.24 The committee's determination should explain why it thinks the outcome is necessary and proportionate. It should say how the committee considered the possible outcomes, starting with the least severe and moving upwards. The determination should say why the committee has decided upon the outcome and explain:

- why the lesser outcomes are not sufficient
- why the next available, more serious, outcome is not necessary or proportionate
- how the outcome chosen will adequately protect the public and the wider public interest

2.25 It is important, and in the interests of fairness, that the professional is given proper reasons, so they can decide whether or not to appeal against the decision. The GPhC, the complainant, the public, the Professional Standards Authority (PSA) and other pharmacy professionals must also be able to understand the reasoning behind the committee's decisions. Any committee which has to consider the case later (for example, at a review hearing) should also be able to properly understand the reasoning behind the original decision.

3 After a decision on the outcome has been made

3.1 Once a committee has made a decision on the outcome it may also impose 'interim measures' that take effect immediately. Once the hearing has ended, there may be a review hearing on another date. This depends on the outcome and circumstances of the case.

Interim measures

3.2 The committee may impose interim measures if it has made a direction for:

- removal from the register
- suspension
- conditions on the professional's entry in the register[19]

3.3 A committee may impose interim measures[20] if it is satisfied that they are needed to protect the public, or are otherwise in the public interest or in the interests of the professional. Any interim measures will take effect immediately and can cover the 28-day 'appeal period'. If the professional appeals against the decision, the measures will stay in force until that appeal is decided.

3.4 Before considering whether to impose interim measures, the committee will invite representations from both parties. When announcing whether it is to impose interim measures, the committee will give its reasons for that decision. When considering whether or not to impose interim measures, the committee should bear in mind:

- the outcome it has reached, and
- any risk to the public

3.5 Even if it decides not to impose interim measures, the committee should make clear in its determination that it has considered them and why it has decided not to impose them.

3.6 The committee must give proper, adequate and clear reasons for imposing interim measures, and make sure the measures are consistent with its finding that the professional's fitness to practise is currently impaired. The reasons should explain why the committee is satisfied that imposing interim measures is:

- needed to protect the public
- otherwise in the public interest, or
- in the interests of the professional

3.7 Interim measures in the form of a suspension may be imposed only if the committee has decided to suspend the professional or remove them from the register. Interim conditions on the professional's entry in the register may only be imposed if the committee's decision is to impose conditions.

[19] Article 60 (3) and (4) – The Pharmacy Order 2010

[20] Article 60 – The Pharmacy Order 2010

Review hearings

3.8 Review hearings[21] can take place when:

- a professional is suspended from the register following a hearing – a committee will usually direct that a review hearing takes place before the period of suspension ends
- a professional is made subject to a 'conditions of practice direction' following a hearing – a committee will usually direct that a review hearing takes place before the period of conditional registration ends

3.9 A committee can review the matter before the scheduled review hearing. For example, the GPhC may have evidence that the professional has practised while suspended or has failed to comply with the conditions imposed upon their practice. Additional outcomes can be decided upon by the committee at the review hearing[22].

3.10 If, in a particular case, the committee decides that a further review hearing is not needed, it should give reasons for making this decision. If there is to be a further review hearing, the committee should explain in its determination the type of evidence the professional would be expected to provide at that hearing.

3.11 If, before a review hearing, the GPhC becomes aware of new evidence* that it wants to bring to the attention of the committee:

- the GPhC may ask for case management directions
- the committee chair may direct that the new evidence be considered at the review hearing, and that these rules are altered to take into account the particular circumstances of the case[23]

*(*For example, evidence of a failure to comply with conditions, or inclusion on any of the barred lists.)*

3.12 At a review hearing, any finding of impairment made by the committee must be based on the original allegation. The committee will need to decide whether the professional's fitness to practise remains impaired after considering all the information now available. The professional is expected to provide evidence that any past impairment has been addressed[24]. The committee must also take this guidance into account at a review hearing[25].

3.13 The GPhC will monitor any conditions imposed on registration. This may mean the committee does not need to ask for an early review of the case. If the GPhC then discovers any breach of, or failure to comply with, the conditions, an early review hearing will take place. This is so that the committee can decide whether to continue, modify or end the conditions and arrive at a more appropriate outcome.

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[21] See Rule 34 – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010 for the procedure followed at a review hearing

[22] Removal not available for health cases

[23] Rule 30 – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[24] Abrahaem v GMC [2008] EWHC 183 (Admin)

[25] Rule 34 (9A) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

Suspension

Considerations	Outcomes	Determination
In some cases it may be obvious that, following a short period of suspension, there will be no value in a review hearing. However, in most cases when a suspension is imposed the committee will need to be sure that the professional is fit to resume practice either unrestricted or with conditions. The committee will also need to satisfy itself that the professional: • has fully appreciated the seriousness of the breach or breaches they have committed • has not committed any further breaches of the standards[26]	If the committee has suspended a professional, it may, following a review, decide that[27]: • their entry be removed from the register (not in a solely health-related case)[28] • the suspension be extended by another period of up to 12 months, to start from the time when the original suspension would otherwise end • their registration be suspended indefinitely, if the suspension has already been in force for at least two years[29] • an indefinite suspension ends • conditions should be imposed when the suspension ends or is terminated	When the committee is: • removing a suspension order and imposing conditions on the professional's registration instead, or • allowing the professional to return to unrestricted practice the determination should explain why the public will not be put at risk by this decision.

[26] Article 48 (1) – The Pharmacy Order 2010

[27] Article 54 (3) (a) – The Pharmacy Order 2010

[28] See paragraph 4.6

[29] This direction must be reviewed if the registrant asks and there has been at least two years since the direction took effect or was reviewed: Article 54 (4) – The Pharmacy Order 2010

Conditions

Considerations	Outcomes	Determination
In most cases when conditions have been imposed the committee will need to be sure that the professional is fit to resume unrestricted practice, or to practise with other conditions or further conditions.	When a professional's entry in the register depends upon their complying with conditions the committee may[30]: • extend the period for complying with the conditions for up to three years starting from the time when the earlier period would have ended • add to, remove or vary the conditions • suspend the entry, for up to 12 months, or • remove the entry from the register	If the committee is reviewing a professional's conditions, the determination should deal with whether, and how, the professional has complied with the conditions. If the committee decides that there has been a failure to comply, it must make specific findings. These must explain which conditions have not been complied with, in what way, and on what evidence the committee has based that decision.

[30] Article 54 (3) (b) – The Pharmacy Order 2010

Part b: Guidance on outcome

This part sets out the GPhC's guidance on what outcomes are, and what issues or factors a committee should consider before deciding on an outcome.

This guidance is not intended to interfere with the committee's powers to choose whatever outcome it decides in individual cases[31].

Committee members should use their own judgement when deciding on the outcome. They should also make sure that any outcome is:

- necessary and proportionate
- based on the individual facts of the case, and
- in the public interest

In deciding on the appropriate outcome, the committee must consider this guidance. If a committee chooses not to follow the guidance, it must explain why it has done this in its reasons for choosing the outcome.

[31] CRHP v (1) GMC (2) Leeper [2004]

4 Available outcomes

4.1 Actions imposed by fitness to practise outcomes are used to protect patients and the wider public interest. This includes declaring and upholding proper standards of conduct and behaviour, and maintaining public confidence in the pharmacy professions and in the regulatory process. Although the effects of some outcomes – for example a suspension or removal from the register – could be punitive, an outcome must not be chosen solely to punish a professional.

4.2 The committee may decide on an outcome whether it decides that a professional's fitness to practise is impaired or not. However, most outcomes only apply once there has been a finding of impairment of fitness to practise. The table below shows the outcomes that are available.

Outcomes for pharmacy professionals

4.3 A committee may apply any of the outcomes set out below. The table includes details of what outcome can be displayed on the online register. Our **publication and disclosure policy** sets out how long they are displayed on the register for.

Take no action

The impact on registration	Circumstances when this may apply
No action will be taken, the case will be closed and it will not be recorded on the register.	This may apply even when impairment is found, but there is no risk to the public or need to decide on a different outcome.

Advice

The impact on registration	Circumstances when this may apply
The committee gives advice to the professional about any issue it considers necessary or desirable. It will not be recorded in the register.	There is no need to take action to restrict a professional's right to practise and there is no continued risk to patients or the public. Advice can only be given to a professional when no impairment is found. The concerns do not amount to an impairment of fitness to practise but are serious enough to need a formal response. The committee should explain why a formal response is needed even though 'no impairment' was found.

Warning

The impact on registration	Circumstances when this may apply
The committee gives a warning to the professional. The details of this warning will be recorded in the register.	A warning may also be given when no impairment is found (see 'advice' above). There is a need to demonstrate to a professional, and more widely to the profession and the public, that the conduct or behaviour fell below acceptable standards. There is no need to take action to restrict a professional's right to practise, there is no continuing risk to patients or the public, but there needs to be a public acknowledgement that the conduct was unacceptable.

Conditions

The impact on registration	Circumstances when this may apply
Conditions[32] place certain restrictions on a professional's registration for the period given by the committee (up to three years). The details of these conditions will be recorded in the register.	There is evidence of poor performance, or significant shortcomings in a professional's practice, but the committee is satisfied that the professional may respond positively to retraining and supervision. There is not a significant risk posed to the public, and it is safe for the professional to return to practice but with restrictions.

Suspension

The impact on registration	Circumstances when this may apply
A suspension prevents a professional from practising for a specific period given by the committee (up to 12 months). The details of the suspension will be recorded in the register.	The committee considers that a warning or conditions are not sufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence. When it is necessary to highlight to the profession and the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser outcome.

[32] Taken from a standard bank of conditions that is made available to the committee: www.pharmacyregulation.org/sites/default/files/good_decision_making_undertakings_bank_january_2016.pdf

Removal

The impact on registration	Circumstances when this may apply
The professional's entry in the GPhC register will be removed and they will no longer be able to work as a pharmacy professional in Great Britain[33].	Removing a professional's registration is reserved for the most serious conduct. The committee cannot choose this outcome in cases which relate solely to the professional's health. The committee should consider this outcome when the professional's behaviour is fundamentally incompatible with being a registered professional.

4.4 The committee may also give advice[34] to any other person or other body involved in the investigation of the allegation on any issue arising from, or related to, the allegation[35].

4.5 If the professional is entered in more than one part of the register, the committee must produce a separate, written determination for each part of the register. The committee may apply one outcome for all parts of the register, or different outcomes for different parts of the register.

Health cases

4.6 If the committee decides that a professional's fitness to practise is impaired solely because of physical or mental ill-health, it cannot direct that the professional be removed from the register[36] at the principal hearing. In the case of a health allegation, the chair may require the person concerned to agree to be medically examined by a registered medical practitioner chosen by the GPhC[37].

Requiring a language assessment

4.7 The committee has the power to require the professional to have a language assessment. The chair may give a direction requiring the professional to[38]:

- have an examination or other assessment of their knowledge of English, and
- provide the registrar with evidence of the result of that examination or assessment

4.8 The committee may order this if it believes that a person registered as a pharmacy professional does not have the knowledge of English needed for safe and effective practice as a pharmacy professional in Great Britain. If the committee is considering this type of case it should take account of the published guidance.

[33] The applicant must wait for five years before applying to be restored to the register.

[34] Whether or not impairment is found

[35] Article 54 (5) – The Pharmacy Order 2010

[36] Article 54 (7) – The Pharmacy Order 2010

[37] Rule 13 (1) (a) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[38] Rule 6 (4) (e) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

Agreement of undertakings

4.9 The committee has the power, when the professional admits that their fitness to practise is impaired, to agree undertakings[39]. Undertakings are promises by the professional on things they will or will not do in the future. They may include restrictions on their practice or behaviour or a commitment to undergo supervision or retraining. Undertakings that are not health related will be recorded in the online register[40].

4.10 Undertakings will only be appropriate if the committee is satisfied that the professional will comply with them – for example, because the professional has shown genuine insight into their behaviour and the potential for remediation. The registrar may refer the matter to the committee for a review hearing if:

- a professional fails to comply with an undertaking, or
- the professional's health or performance deteriorates or otherwise gives further cause for concern about their fitness to practise[41]

Corporate bodies

4.11 The committee has the power, if it thinks fit, to agree appropriate undertakings with the 'section 80' party[42], or to give advice or a warning, instead of giving a direction under section 80 of the Medicines Act 1968 to remove the corporate body from the register[43].

4.12 If the GPhC becomes aware that a party has failed to comply with any undertakings agreed, the committee must[44]:

- consider the matter again, and
- reconsider the outcome. It may instead issue a direction under section 80(1) of the Medicines Act 1968 against the body corporate, or under section 80(4) against an individual

4.13 The committee also has the power[45] to deal with 'disqualification allegations' made against a corporate body that carries on a retail pharmacy business. The committee may direct that:

- a corporate body should be disqualified for the purposes of Part IV of the Medicines Act 1968
- a 'representative' of the corporate body should be disqualified as being a representative for the purposes of Part IV of the Medicines Act 1968
- the registrar should remove from the register of premises some or all of the premises at which the corporate body carries on retail pharmacy

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[39] Rule 26 (1) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[40] www.pharmacyregulation.org/sites/default/files/gphc_publication_and_disclosure_policy_vseptember_2014.pdf

[41] Rule 45(3) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[42] Defined in Rule 2 as 'an individual who, or a body corporate which, is subject to proceedings before the Committee in connection with the giving a direction under section 80(1) or (4) of the Act (or, where appropriate, their representatives)'

[43] Rule 26(2) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[44] Rule 32(18) – The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010

[45] Section 80 Medicines Act 1968

- the registrar should remove from the register of premises, for a limited time, some or all of the premises at which the corporate body carries on retail pharmacy[46]

Bringing a prosecution

4.14 If the committee believes that the GPhC should consider using its powers to bring criminal proceedings it must tell the registrar about this[47].

[46] Section 80(3) of the Medicines Act 1968

[47] www.pharmacyregulation.org/sites/default/files/Prosecution%20Policy%2C%2010-11-2011_0.pdf

5 Deciding on the outcome

5.1 When making its decision the committee must keep in mind the overall objectives of the GPhC. The committee should also consider the full range of outcomes. It should use its discretion and decide on an outcome that is necessary and proportionate. By 'proportionate', we mean that an outcome should be no more serious than it needs to be to achieve its aims[48]. The committee should also make sure any outcome is sufficient to protect the public. This involves considering:

- whether it is sufficient to protect the health, safety and wellbeing of the public
- whether it is sufficient to maintain public confidence in pharmacy, and
- whether it is sufficient to maintain proper professional standards and conduct for pharmacy professionals

Key factors to consider

5.2 Making sure that a hearing has the appropriate outcome is important for both public confidence in the profession and in the way it is regulated. In deciding on the most appropriate outcome, the committee should consider:

- the extent to which the professional has breached the standards[49] as published by the GPhC
- the interests of the professional, weighed against the public interest
- the overall objectives of the GPhC
- the personal circumstances of the professional and any mitigation* they have offered or which the committee has identified in its findings
- that the decision is sufficient to protect the public
- any testimonials and character references given in support of the professional
- any relevant factors that may aggravate* the professional's conduct in the case
- any statement of views provided to the committee by a patient or anyone else affected by the conduct of the professional
- any submissions made to the committee by the GPhC's representative, the professional or their representative
- the contents of this guidance
- any other guidance published by the GPhC

** See paragraphs 5.10 to 5.23 for an explanation of mitigating and aggravating factors.*

5.3 To make sure that the outcome is proportionate, the committee should consider each available outcome, starting at the lowest, and decide if it is appropriate to the case. If it is not, the

[48] Chaudhury v General Medical Council [2002] UKPC 41

[49] Article 48 (1) – The Pharmacy Order 2010

committee should consider the next outcome, and so on, until it decides that a particular outcome is appropriate[50].

5.4 The committee should also consider the outcome immediately above the one it has decided on and give reasons why a more serious outcome is not necessary and proportionate.

5.5 The term of a suspension can be up to 12 months. How long a suspension should be is for the committee to decide, taking into account the seriousness or relevant factors of the particular case. The period should be considered against the facts of the case and be proportionate. The committee must give reasons for the period of suspension it has chosen, including the factors in the case that led it to decide that the particular period of suspension was appropriate. This applies whether the committee has opted for a 12-month suspension or a shorter period.

5.6 The period for conditions of practice may not be more than three years. It is for the committee to decide what conditions to apply and for how long they should last. Conditions should be imposed to protect the public, or for other reasons in the public interest or in the interests of the professional.

The public interest

5.7 In reaching a decision on what outcome to choose, the committee should give appropriate weight to the wider public interest[51]. In the context of a fitness to practise hearing, public interest considerations include:

- protecting the public
- maintaining public confidence in the profession
- maintaining proper standards of behaviour

5.8 The committee is entitled to give greater weight to the public interest than to the consequences for the professional[52]. Even if an outcome will have a punitive effect,[53] it may still be appropriate if its purpose is to achieve one or more of the three outcomes listed in paragraph 5.7[54]. The committee should make sure that the public interest considerations are reflected in the reasons for deciding on a particular outcome.

5.9 Mr Justice Newman[55] described indicative sanctions guidance and the public interest in the following way: “Those are very useful guidelines and they form a framework which enables any tribunal, including this court, to focus its attention on the relevant issues. But one has to come back to the essential exercise which the law now requires in what lies behind the purpose of sanctions, which, as I have already pointed out, is not to be punitive but to protect the public interest; public interest is a label which gives rise to separate areas of consideration.”

[50] Giele v General Medical Council [2005] EWHC 2143 (Admin)

[51] CHRE v Nursing and Midwifery Council (Grant)

[52] Marinovich v General Medical Council [2002] UKPC36

[53] Bolton v The Law Society [1994] 2 All ER 286

[54] Laws LJ in Rashid and Fatnani v GMC [2007] 1 WLR 1460

[55] R (on the application of Abrahaem) v GMC [2004]

Relevant mitigating and aggravating factors

5.10 When a committee makes decisions about a pharmacist or pharmacy technician's fitness to practise and the appropriate outcome, it must be sure that it has been presented with the evidence it needs to make a fair and proportionate decision. It must take into account the context of a case. By 'context' we mean the circumstances in which the alleged incident took place, including any relevant personal matters (a bereavement, for example), and what has happened since the alleged incident took place. This includes considering any aggravating and mitigating factors (depending on the individual circumstances of each case), and bearing in mind that the main aim is to protect the public.

5.11 Aggravating factors are the circumstances of the case that make what happened more serious. Mitigating factors are the opposite. They may appear in the facts of a case as circumstances, behaviours, attitudes or actions.

5.12 Whether a factor amounts to mitigation or aggravation is entirely a matter for the committee to decide. In each case, the committee must consider both mitigating and aggravating features in the evidence they have considered.

Circumstances

5.13 The circumstances in which the allegation arose may include important factors when making a decision on an outcome. The committee may want to consider the implications or risks to patient safety as a result of the incident. It may also want to consider, for example:

- whether the incident was a 'one-off' one or repeated
- the setting in which the incident took place
- any relevant personal matters
- if there is a relevant history of fitness to practise concerns

5.14 The committee should consider if the incident involved:

- an abuse or breach of trust
- an abuse by the professional of their professional position
- any financial gain on the part of the professional
- the extent to which the professional's actions and behaviour were affected by their being the victims of discrimination

5.15 It should also consider any previous committee findings involving the professional that are relevant to the case.

5.16 Other factors might include if the professional was under the influence of alcohol or drugs, or if there was harm or risk of harm to a patient or another person present.

Behaviour and attitude

5.17 Evidence of the professional's behaviour and attitude before, during and after the incident in question and before and during proceedings, is also important. This could include for example, co-operating with the investigation or being candid with patients and the public when things go wrong. The committee may want to consider whether the professional has:

- shown any remorse or set out to put things right – including by offering an apology
- demonstrated insight into the concerns in question and taken actions to avoid repeating them
- been open and honest with the committee

5.18 Evidence may also be presented by way of references and testimonials. We say more about this below.

Insight and remediation

5.19 The GPhC believes that insight and remediation are key factors for committees to consider during fitness to practise proceedings. The expectation is that a professional:

- can accept and understand that they should have behaved differently (insight), and
- will take steps to prevent a reoccurrence (remediation)

5.20 When assessing insight the committee will need to take into account factors such as whether the professional has:

- genuinely demonstrated insight – not only consistently throughout the hearing but also through their actions after the incident took place, and
- demonstrated understanding and insight after the committee finding

5.21 When deciding what action to take, decision makers must consider:

- the nature of the concern
- whether the actions can be remediated, and
- if a professional can demonstrate insight

There may be some cases where a professional's conduct is so serious that it is not remediable. This means that even though the professional may provide evidence of insight and remediation, the conduct is so serious that it is not appropriate to take this evidence into account when considering an outcome. Examples where this may occur include concerns involving discriminatory behaviour or sexual misconduct. This is because regulatory action is necessary to ensure public protection and maintain public confidence in pharmacy, and a professional's involvement in these matters can undermine this.

Expressions of regret and apology

5.22 This section deals specifically with how cultural factors and other circumstances may be relevant to expressions of regret and apology and how people express insight. There is further information about the duty of candour and the requirement on pharmacy professionals to be open and honest in section 6 below.

5.23 Treating everyone fairly includes being aware of, and taking into account, cultural differences and other circumstances (such as ill health) that may affect the way people react to situations or communicate.

5.24 The committee should be aware that there may be cultural differences or a professional's personal circumstances, such as ill-health, the impact of a health condition or disability that may affect the way an individual communicates and expresses themselves. This could affect, for example, how an apology, insight or expression of regret is framed and delivered. This is particularly the case for individuals who are communicating in a second language and may use conventions of their first language to construct their sentences or statements. This may be reflected in their intonation and could alter the intended meaning when spoken in their second language. As a result, they may not adhere to the conventions or display the subtleties or nuances of their second language.

5.25 Expressions of apology, and how an apology is communicated, can differ across cultures, and be affected by religion and beliefs. For example, in some cultures written apologies are not the norm. In addition, the committee should be aware that a neurodiverse individual may also express their remorse or sorrow in a different way.

5.26 There may also be differences in the way individuals use non-verbal cues to communicate. This will include, among other things, facial expressions, eye contact and gestures. For example, a professional with a sight impairment may have difficulty making eye contact with committee members. The committee should be aware of and sensitive to these issues when deciding how a professional frames their insight and remorse, and in judging their behaviour and attitude during the hearing.

5.27 The committee should be conscious of these issues when assessing what weight to give relevant factors in determining sanctions. The committee should note that it is not just about how individuals communicate, and it should also consider the support professionals may need to understand the information that is communicated to them during the hearing.

Testimonials

5.28 Testimonials (or references) can have an important bearing on the outcome of a fitness to practise hearing in that the referee could provide evidence or information which is material to the extent to which the professional has either remediated their failings, reflected on or shown insight into their failings or expressed remorse or apologies for their failings. However, references and testimonials that simply support the professional and/or provide a view on their character in general terms are unlikely to be directly relevant to the question of current impairment and/or to the decision on an appropriate sanction.

5.29 Committees should first consider whether these are genuine and can be relied upon. The committee should consider whether the authors of the testimonials were aware of the events leading to the hearing and what weight, if any, to give the testimonials. The weight given to evidence in references and testimonials is a matter for the committee, however, the committee may place greater emphasis on evidence of this nature that is verified.

5.30 The committee should be aware that in some circumstances, there may be cultural or other reasons why a professional may not want to ask for testimonials (or references). For example, sharing information about their investigation with family members or colleagues may affect their private lives, and their reputation with their family and community. The committee should bear

this in mind and not make assumptions about why there is an absence of this type of evidence. Equally the committee should not speculate as to what may have been said had any references or testimonials been requested.

5.31 The committee should note that variation in the quantity, quality and spread of references and testimonials between cases does not necessarily relate to the good standing of a pharmacy professional. It should also note that pharmacy professionals who qualified outside the UK and have just started working in the UK may find it difficult to get references and testimonials.

5.32 As with other mitigating or aggravating factors, any references and testimonials will need to be weighed appropriately against the nature of the facts found proved and be considered at the appropriate stage of the process. The committee will need to consider the appropriate stage for them to take account of personal mitigation and testimonials.

5.33 Testimonials prepared before a hearing should be considered in the light of the factual findings made at the hearing. Testimonials or other evidence which confirms the steps taken by the professional to remedy the behaviour which led to the hearing (for example from professional colleagues) and evidence of how the professional currently practices may be relevant when the committee is considering the issue of impairment. This evidence should not be left to the outcome stage[56].

Actions

5.34 The professional's actions are important elements for the committee to consider when deciding on an outcome. Factors the committee may want to consider include whether the:

- conduct was pre-meditated or not
- professional attempted to cover up wrongdoing
- conduct was sustained or repeated over a period of time
- professional took advantage of a vulnerable person

[56] Mr Justice McCombe said in Azzam v General Medical Council [2008]

6 More guidance on particular areas

6.1 There are often certain case types in fitness to practise hearings that are more complex than usual when deciding what outcome to apply. We believe that giving more guidance – including the relevant case law, legal principles and the GPhC view on particular areas – will help to ensure proportionate and consistent decision making. This is intended to help committees in their decision making.

Sexual misconduct

6.2 Sexual misconduct – whatever the circumstances – undermines public trust in the profession and has a significant impact on the reputation of pharmacy professionals. In some circumstances it can present a significant and immediate risk to patient safety. It covers a wide range of behaviour, including sexual harassment, sexual assault, physical examinations of patients that are without consent or unnecessary, and serious sexual offences which lead to criminal convictions.

6.3 The GPhC believes that some acts of sexual misconduct will be incompatible with continued registration as a pharmacist or pharmacy technician. Removal from the register is likely to be the most appropriate outcome in these circumstances, unless there is evidence of clear, mitigating factors that cause a committee to decide that such an outcome is not appropriate. The misconduct is particularly serious if:

- there is a conviction for a serious sexual offence
- there is an abuse of the special position of trust that a professional has
- it involves a child (including accessing, viewing, or other involvement in images of child sexual abuse[57]) or a vulnerable adult[58]
- the professional has been required to register as a sex offender or has been included on a barred list

6.4 This is not a full list. It is meant to show that in cases of this type, given the risk to patients and the impact on public confidence in the profession, removal from the register is likely to be the most necessary and proportionate outcome[59]. If a committee decides on an outcome other than removal it should explain fully why it made this decision. This is so that it can be understood by people who have not heard all the evidence in the case.

6.5 The misconduct can take place in many settings. This can be:

- in a private setting with family members
- in a social context, or
- in the course of a professional's work with patients and colleagues

It is therefore important that the committee carefully considers each case on its merits, and takes decisions in the light of the particular circumstances of the case and the risk posed to

[57] CHRP v (1) GDC and (2) Mr Fleischmann

[58] Disclosure & Barring Service or Disclosure Scotland scheme

[59] Dr Haikel v GMC (Privy Council Appeal No. 69 of 2001)

patients and the public. The committee should also refer to the GPhC's guidance on maintaining clear sexual boundaries[60].

6.6 A professional may have committed an offence but not be included on a barred list. If so, and if the committee is in any doubt about whether they should return to work without any provisions to ensure public protection, the professional should not be granted unrestricted registration. A committee does not need to make recommendations on whether a professional should be referred to a barring authority, as this will be considered by the GPhC.

6.7 Given the role of pharmacists and pharmacy technicians, and their closeness to and regular contact with patients (including children and vulnerable adults), there is also the potential for inappropriate, but not sexual, relationships. The GPhC view is that committees should regard as serious any predatory behaviour, or abuse of position, that results in inappropriate relationships with vulnerable patients, or with colleagues. Committees should carefully consider the context of the relationship and the vulnerability of the people involved when deciding on an outcome.

Dishonesty

6.8 Regulators ensure that public confidence in a profession is maintained. This is a long-established principle, and standards[61] state that professionals should act with honesty and integrity to maintain public trust and confidence in the profession. There are some acts which, while not presenting a direct risk to the public, are so serious that they undermine confidence in the profession as a whole. The GPhC believes that dishonesty damages public confidence, and undermines the integrity of pharmacy professionals. However, cases involving dishonesty can be complicated – committees should carefully consider the context and circumstances in which the dishonesty took place. Therefore, although serious, there is not a presumption of removal in all cases involving dishonesty.

6.9 Some acts of dishonesty are so serious that the committee should consider removal as the only proportionate and appropriate outcome. This includes cases that involve intentionally defrauding the NHS or an employer, falsifying patient records, or dishonesty in clinical drug trials.

6.10 When deciding on the appropriate outcome in a case involving dishonesty, the committee should balance all the relevant issues, including any aggravating and mitigating factors. It is important to understand the context in which the dishonest act took place and make a decision considering the key factors. The committee should then put proper emphasis on the effect a finding of dishonesty has on public confidence in the profession[62].

Duty of candour

6.11 Acting with openness and honesty when things go wrong is an essential duty for all pharmacy professionals. Our published standards say professionals must be candid and honest when things go wrong[63]. The GPhC believes it is important that there is an environment and culture in pharmacy where pharmacy owners, superintendent pharmacists, pharmacists and pharmacy technicians:

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60 www.pharmacyregulation.org/sites/default/files/gphc_guidance_on_sexual_boundaries_14.pdf

61 Article 48 (1) – The Pharmacy Order 2010

62 R v General Optical Council [2013] EWHC 1887 (Admin) and Siddiqui v General Medical Council [2013] EWHC 1883

63 Article 48 (1) – The Pharmacy Order 2010

- are open and honest with patients and the public when things go wrong (because of either what they have done, or what someone else has done), and
- can raise concerns with employers

6.12 Professionals are expected to be open and honest with everyone involved in patient care. Committees should therefore see professionals' candid explanations, expressions of empathy and apologies as positive steps before, and during, a hearing. However, these will not usually amount to an admission of impairment by the professional. So, unless there is evidence to prove otherwise, the committee should not treat them as such.

6.13 The joint statement on candour clearly sets out the importance of this issue[64]. Therefore, the GPhC's view is that committees should take very seriously a finding that a pharmacy professional took deliberate steps to:

- avoid being candid with a patient, or with anyone involved in a patient's care, or
- prevent someone else from being candid

6.14 It should consider outcomes at the upper end of the scale when dealing with cases of this nature.

Discriminatory behaviour

6.15 Unlawful discriminatory behaviour and attitudes undermine public confidence and trust in the pharmacy professions and can have an impact on the reputation of professionals. It may also impact on maintaining trust with patients, colleagues and members of the public.

6.16 Unlawful discrimination means treating a person unfairly because of their protected characteristics[65] (see below). However, there are also circumstances when certain forms of discrimination are lawful under the Equality Act. When we talk about concerns involving discrimination, we are referring to the type of conduct that is unlawful under the Equality Act and which would be seen as unfair treatment.

6.17 All forms of unlawful discriminatory behaviour on the part of professionals towards patients, the public and colleagues are unacceptable. Discrimination can be direct and indirect and exist in a number of forms including harassment and victimisation[66].

6.18 Importantly, it has the potential to pose a serious risk to patient safety. For example, where discrimination has resulted in treatment not being provided, or a delay in treatment being provided, this may impact the physical, emotional and/or psychological wellbeing of a patient or member of the public which may affect how they access health services in the future. Where discrimination is towards colleagues, in addition to any harm caused to them, it may impact on patient safety by causing breakdowns in communication and/or in the collaborative working needed to deliver safe patient care.

6.19 Pharmacy professionals must treat their colleagues and patients fairly, whatever their life choices and beliefs. In line with our standards, we expect professionals to:

[64] www.pharmacyregulation.org/sites/default/files/joint_statement_on_the_professional_duty_of_candour.pdf

[65] Section 4 of the Equality Act

[66] Section 26 of the Equality Act

- recognise and value diversity, and respect cultural differences – making sure that every person is treated fairly, whatever their values and beliefs.
- recognise their own values and beliefs but do not impose them on other people
- take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs

6.20 When deciding on an outcome, the committee should balance all the relevant issues, including any aggravating and mitigating factors. For example, when dealing with a concern that alleges discrimination on the basis of ethnicity or race the Committee should, when deciding whether the conduct was racially motivated, consider whether the:

- Action/words had a purpose behind it which at least in significant part was referable to race; or
- Act done in a way showing hostility or a discriminatory attitude to the relevant racial group[67].

6.21 Because of the serious nature of these types of concerns and the impact on public trust and confidence in the profession, the committee should usually consider outcomes at the upper end of the scale. More serious outcomes are likely to be appropriate where a case involves discrimination against patients, colleagues or other people who share protected characteristics, either within or outside their professional life or where there was a pattern of repeated discriminatory behaviour, behaviour was intentional, frequent and with very negative consequences for patients.

6.22 This can include:

- abusive verbal comments, including hate speech, or offensive writing (including on social media or public platforms) towards someone because of their protected characteristics
- comments on social media or public platforms about a particular group of people because of their protected characteristics
- Unwanted behaviour, including spoken or written words, abuse, imagery, gestures, expressions, mimicry, jokes and others
- discrimination, whether direct or indirect, against individuals or groups in the provision of services
- treating a patient less favourably because of a protected characteristic

[67] Lambert-Simpson v HCPC (2023 EWHC 481 Admin)

- treating a colleague less favourably because of their protected characteristics, for example not offering a training or development opportunity, complicity in discrimination by others or a failure to challenge discriminatory practices
- other general factors that may not be captured by the legislation under protected characteristics for example, relating to socio-economic factors.

Raising concerns

6.23 The GPhC believes that the individual decisions of pharmacy professionals make the most significant and positive contribution to quality improvements in pharmacy and in managing risks to patients. Failing to raise concerns can lead to failures in healthcare and cause significant risk to patients.

6.24 Therefore, pharmacists and pharmacy technicians must act to prevent problems arising in the first place. It is important that there is an environment and culture in pharmacy where individuals are supported in raising concerns about standards of care and risks to patient safety. This is reflected in the standards[68].

6.25 The GPhC believes that a committee should take very seriously a finding that a professional did not raise concerns when patient safety is at risk. It must consider outcomes at the upper end of the scale when cases involve a failure to raise concerns. In the most serious cases, it must remove professionals from the register to maintain public confidence.

6.26 Our guidance on raising concerns[69] explains the importance of raising concerns, and the steps that a professional will need to consider taking when raising a concern.

[68] Article 48 (1) – The Pharmacy Order 2010

[69] www.pharmacyregulation.org/sites/default/files/GPHC%20Guidance%20on%20raising%20concerns.pdf

General Pharmaceutical Council

Update on the consultation proposals for Chief Pharmacist standards

Meeting paper for Council on 07 December 2023

Public

Purpose

To provide Council with an update on the consultation proposals for Chief Pharmacist standards.

Recommendations

The Council is asked to note the updates and approve the proposals for consultation.

1. Introduction

1.1 At the previous Council meeting on 9 November 2023, Council provided feedback on the consultation proposals in relation to the development of new standards for Chief Pharmacists. The purpose of the standards is to maintain and strengthen pharmacy governance by providing clarity around the role, responsibilities, and accountabilities of Chief Pharmacists.

1.2 We have addressed the feedback we received from Council and are resubmitting the amended consultation proposals for Council's consideration.

2. Issues raised by Council

2.1 At the November meeting Council raised several important points which we have addressed and detailed below.

2.2 A question was raised about whether the standards could contain a full list of the relevant settings covered by the Order. Although we have expanded the list to highlight the diversity of settings covered, the sometimes rapid changes happening in the pharmacy sector means that it is not practical to try and provide an exhaustive list. However, when the standards are published we will provide accompanying FAQs (which can be regularly updated, unlike standards), which will signpost to relevant information.

2.3 Although the importance of equality, diversity, and inclusion (EDI) was implicit in the standards, Council asked for an explicit reference to be made and this has now been done.

2.4 Council also highlighted the role of the standards in maintaining, as well as strengthening, governance and the standards have now been amended to include this point.

2.5 A question was raised about whether the standards were broad enough to be applicable to the wide variety of eligible settings, including Integrated Care Boards (ICBs) and ambulance Trusts, as well as those managing controlled drugs. Additional meetings with Chief Pharmacists from ICBs, ambulance trusts, and those managing controlled drugs have now been held, and the feedback was that in their view, the standards could be applied in all eligible settings. One of the questions in the consultation also covers this issue, and we will take note of the consultation responses.

2.6 The Council also asked about how we could provide assurance that the standards are being met, and what enforcement action could be taken if needed.

2.7 Chief Pharmacists are personally accountable for meeting the standards and must be able to justify their conduct and the decisions they make. Where an organisation chooses to have a Chief Pharmacist or equivalent role in post, the postholder is required to meet these standards. In these circumstances, if a Chief Pharmacist or equivalent fails to meet the standards their fitness to practise may be called into question.

2.8 Dealing with fitness to practise concerns is at the heart of our commitment to protecting patients and the public and maintaining public confidence. Our fitness to practise process is part of the compliance mechanism to make sure that Chief Pharmacists meet the relevant standards. Fitness to practise also forms part of the process to make sure that all registered pharmacists and pharmacy technicians, meet the standards for pharmacy professionals.

2.9 The GPhC does not have direct regulatory authority of most settings where Chief Pharmacists operate such as hospitals, prisons, and care homes. We have spoken again with the Care Quality Commission (CQC), as the regulator in England for many of the settings covered by the standards. CQC informed us that they meet with Chief Pharmacists on at least an annual basis, to discuss leadership within their service.

We work closely with CQC, who contact us if they have any concerns about the practise of pharmacists (including Chief Pharmacists) or pharmacy technicians and we would then investigate. We have similar arrangements with Healthcare Improvement Scotland and Healthcare Inspectorate Wales.

2.10 As a means of monitoring and evaluating the standards for Chief Pharmacists (and those for Responsible and Superintendent Pharmacists), we are working with the 'Post registration assurance of practice advisory group', to consider how revalidation could be used by those in leadership roles to demonstrate how they are meeting our standards.

2.11 With regards to the role and responsibilities of Chief Pharmacists and whether they are meeting our standards, we would also expect them to have a line manager, who would conduct regular performance assessments and reviews, and to raise any concerns with us.

2.12 We have now met with the Department of Health and Social Care (DHSC), which has confirmed that our approach to providing assurance that our standards are being met is aligned with the intentions of the Order. The view of the DHSC is that assurance the standards are being met should be determined by investigation, that is, by concerns raised either by staff, patients and the public, or other regulators. These concerns would then need investigation to determine whether the Chief Pharmacist in question had met our standards, and if further investigation around their fitness to practise was needed.

3. Key considerations

3.1 It should be noted that the legislation is enabling, which means that an organisation can choose not to benefit from the defences, in which case they will not be required to have a Chief Pharmacist or their equivalent role, and in those circumstances our standards for Chief Pharmacists will not apply. However, we would encourage organisations to acknowledge and follow the standards as good practice, and to strengthen pharmacy governance.

3.2 Where an organisation chooses to have a Chief Pharmacist or equivalent role in post, the postholder is required to meet the standards. In these circumstances, if a Chief Pharmacist fails to meet these standards, it may lead to us investigating concerns about a Chief Pharmacist's fitness to practise.

3.3 Some stakeholders have asked whether guidance, with case studies, will be provided. The consultation feedback will provide an indication of the need for guidance, and further discussions will take place once analysis of the responses has been completed.

4. Timeframe

4.1 The consultation, subject to Council approval, will be open for 12 weeks and we propose to launch it in January 2024.

5. Equality and diversity implications

5.1 An Equality Screening and Impact Assessment (ESIA) is being undertaken for the strengthening pharmacy governance programme of work. The section on Chief Pharmacists will be published on the GPhC website, together with the consultation analysis report, when the standards have been signed off by the Council, the Privy Council, and Secretary of State.

5.2 With regards to meeting our standards, expectations are the same for all pharmacy professionals regardless of whether they identify as having one or more of the protected characteristics under the Equality Act 2010.

6. Communications

6.1 Extensive engagement with a broad range of stakeholders has already been carried out using various channels, including individual one-to-one meetings, virtual focus groups, and webinars.

6.2 A communications and engagement plan has been developed for the consultation. Communications will be sent to stakeholders using regular channels including the GPhC website, email, and social media.

7. Resource implications

7.1 The resources for this work have been accounted for in existing budgets.

8. Risk implications

8.1 Although Chief Pharmacists may not provide care directly to patients and the public, their actions have an impact on the safe and effective care that patients and the public receive, and on the confidence that members of the public have in pharmacy.

8.2 Failure to effectively engage with a wide audience, including patients and the public could undermine the standards and their future use.

8.3 Failure to develop robust standards for Chief Pharmacists may mean that staff will not feel confident about reporting errors and consequently may not learn from their mistakes or those of colleagues, thereby reducing patient safety.

8.4 In relation to regulatory standards, Council has indicated acceptance of a greater degree of risk in maintaining and updating standards. This is because being too risk averse, or conservative, in setting standards could become counter-productive and mean we fail to deliver a regulatory model that meets society and pharmacy's needs.

9. Monitoring and review

9.1 The standards will be monitored and reviewed on an on-going basis with the normal review cycle being five years.

9.2 As a means of monitoring and evaluating these standards (and those for Responsible and Superintendent Pharmacists), we are looking to the work being done by the 'Post-registration assurance of practice advisory group', and considering how revalidation could be used by those in leadership roles to demonstrate how they are developing their practice and improving patient safety.

10. Recommendations

The Council is asked to note the updates and approve the proposals for consultation.

[Mark Voce, Director of Education and Standards
General Pharmaceutical Council

Annette Ashley, Head of Policy and Standards

Balraj Pawar, Policy Manager

[Enter date final version signed-off]

2023

Appendix 1

Standards for Chief Pharmacists (or equivalent)

Foreword

[From the Chair and Chief Executive/Registrar. To be added].

About us

The General Pharmaceutical Council (GPhC) regulates pharmacists, pharmacy technicians and registered pharmacies in Great Britain.

What we do

Our role is to protect the public and give them assurance that they will receive safe and effective care when using pharmacy services. Our main work includes:

- Setting standards for the education and training of pharmacists and pharmacy technicians, and approving and accrediting their qualifications and training,
- Maintaining a register of pharmacists, pharmacy technicians and pharmacies,
- Setting the standards of conduct and performance that pharmacy professionals must meet throughout their careers,
- Setting the standards of continuing professional development that pharmacy professionals must achieve throughout their careers,
- Investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public,
- Setting standards for registered pharmacies which require them to provide a safe and effective service to patients,
- Inspecting registered pharmacies to check if they are meeting our standards.

Introduction

The Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022

The purpose of this Order is to remove the threat of criminal sanctions for inadvertent preparation and dispensing errors for pharmacy staff working in hospitals and similar settings. The Order extends the defences that already apply to pharmacy staff working in registered pharmacies, to pharmacy staff working in hospitals and other relevant pharmacy services, such as care homes, some Integrated Care Boards (ICBs), some ambulance trusts, prisons, and other places where people are lawfully detained.[1] If you are in doubt about whether you or staff within your organisation are able to benefit from the defences, please seek advice from your organisation's legal team.

[1] A list of eligible settings can be found in section 67F of the Medicines Act 1968.

Extending the defences will provide consistency across the sector and enable and incentivise the reporting of preparation and dispensing errors, leading to increased shared learning from errors, thereby improving patient safety.

The Order gives the GPhC various new powers, such as the power to set professional standards for Chief Pharmacists, including a description of their professional responsibilities. The production of new standards will maintain and strengthen pharmacy governance by providing clarity around the role, responsibilities, and accountability of Chief Pharmacists. Strengthening governance will create a framework where the likelihood of preparation and dispensing errors is reduced, and a culture where staff feel able to report any errors and learn from them.

To benefit from the defences as set out in the Order, the hospital (or other eligible pharmacy setting) must have a Chief Pharmacist in post, who must be a registered pharmacist with the appropriate skills, training, and experience. Where an organisation chooses to have a Chief Pharmacist or equivalent role in post, we require the postholder to meet the standards set out in this document.

It should be noted that the legislation is enabling, which means that an organisation can choose not to benefit from the defences, in which case they will not be required to have a Chief Pharmacist or their equivalent role, and in those circumstances our standards for Chief Pharmacists will not apply. However, we would encourage organisations to acknowledge and follow the standards as good practice and to strengthen pharmacy governance.

The development of the Chief Pharmacist standards is the first part of a programme of work to strengthen pharmacy governance. The programme also includes the production of rules and professional standards for Responsible Pharmacists, and professional standards for Superintendent Pharmacists.

The Chief Pharmacist role

The 2022 Order requires eligible pharmacy settings to have a Chief Pharmacist, or equivalent postholder, in place if those organisations wish to benefit from the defences from criminal prosecution in the event of an inadvertent preparation or dispensing error. We require the postholder to meet both our **standards for pharmacy professionals** as well as the new standards for Chief Pharmacists. The new standards describe the role and responsibilities of Chief Pharmacists and set standards of conduct and performance in relation to them.

Chief Pharmacists are senior healthcare professionals responsible for providing leadership, expertise, oversight, and management of pharmacy services within an organisation. The role includes planning and allocating resources, enhancing productivity, providing value for money, as well as making sure that pharmacy services meet the needs of the communities they serve and improve health outcomes. Their work contributes to the safe, high quality and effective provision of services in these settings.

The title ‘Chief Pharmacist’ is not a required term, and other titles, such as Director of Pharmacy are often used. If a title other than Chief Pharmacist is used, the requirements set out in section 67F (4) of the Medicines Act 1968 and our requirements contained within these standards must be included in the job description and must be met if the organisation wants to benefit from the defences.

Section 67F (4) of The Medicines Act 1968 sets out the role of the Chief Pharmacist (or equivalent) as someone:

Who plays a significant role (irrespective of whether other individuals also do so) in:

I. The making of decisions about how the whole or a substantial part of the activities of the pharmacy service are to be managed or organised, or

II. The actual managing or organising of the whole or a substantial part of those activities

- Has the authority to make decisions that affect the running of the pharmacy service as far as concerns the sale or supply of medicinal products, and
- Is responsible for securing that the pharmacy service is carried on safely and effectively.

The Chief Pharmacist or equivalent role must satisfy these requirements if their organisation wants the pharmacy staff to benefit from the defences to prosecution. We have built upon these requirements in producing the standards for Chief Pharmacists. Failing to meet these standards may lead to us investigating concerns about a Chief Pharmacist's fitness to practise.

The standards for Chief Pharmacists

The standards for Chief Pharmacists set out the professional responsibilities, as well as the knowledge, conduct, and performance required by a Chief Pharmacist to support the organisation, and its staff, to deliver safe and effective pharmacy services including the preparation and dispensing of medicines.

The Chief Pharmacist plays a critical leadership role in making sure pharmacy services are delivered safely and effectively. Chief Pharmacists must meet the following standards:

1. **Provide strategic and professional leadership,**
2. **Develop a workforce with the right skills, knowledge, and experience,**
3. **Delegate responsibly and make sure there are clear lines of accountability,**
4. **Maintain and strengthen governance to ensure safe and effective delivery of pharmacy services.**

The standards are designed to be outcome focused, and Chief Pharmacists should make sure that they can demonstrate they are meeting the standards whilst considering the requirements of the setting in which they work. The standards are also a statement of what patients and those working with Chief Pharmacists can expect of them.

How to demonstrate that the standards are being met

A Chief Pharmacist can provide assurance that the standards are being met in several ways:

- Through a regulatory inspection discussion, including those with the Care Quality Commission,
- Through referencing the requirements of their role as a Chief Pharmacist when undertaking revalidation,
- Through investigation if a concern is raised with the regulator by a member of staff, a patient or a member of the public, or through inspections or other regulatory activity carried out by the Care Quality Commission, Healthcare Improvement Scotland, or Healthcare Inspectorate Wales,
- Through the regular performance reviews with their line manager.

Applying the standards

The standards have been developed to apply to all Chief Pharmacists regardless of the setting in which they work. Although Chief Pharmacists may not provide care directly to patients and the public, their actions have an impact on the safe and effective care that patients and the public receive, and on the confidence that members of the public have in pharmacy.

Chief Pharmacists are personally accountable for meeting the standards and must be able to justify their conduct and the decisions they make.

Alongside these standards, Chief Pharmacists must also meet the GPhC's **standards for pharmacy professionals** which need to be met by all pharmacy professionals. Chief Pharmacists should also follow their organisation's policies and procedures; and meet the requirements and follow the advice from other relevant regulatory bodies and inspectorates, such as the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Improvement Wales, and the Medicines and Healthcare products Regulatory Agency, as well as any other relevant legislation.

There will be times when Chief Pharmacists are faced with conflicting legal and professional responsibilities. Or they may be faced with complex situations that mean they have to balance competing priorities. The standards for pharmacy professionals and those for Chief Pharmacists provide a framework to help them when making professional judgements. We expect Chief Pharmacists to consider these standards, their legal duties and any relevant guidance when making decisions including those covering medicines legislation.

Standard 1: Provide strategic and professional leadership.

As leaders, Chief Pharmacists play a central role in setting the strategic direction required to deliver safe and effective pharmacy services. It is part of the role of the Chief Pharmacist to help empower and guide pharmacy professionals and the wider workforce to deliver improved patient outcomes.

Chief Pharmacists must:

- **Have a clear vision and strategy to deliver safe and effective pharmacy services,**
- **Lead by example, taking responsibility for their own professional growth and development,**
- **Be able to influence and work collaboratively to meet the needs of patients and contribute to shared organisational and system objectives,**
- **Embrace research, technology, and innovation to enhance safety and support service transformation.**

Examples of how to meet this standard.

Below are examples of how Chief Pharmacists can meet this standard. It is not an exhaustive list and should be used as a prompt and not as a checklist:

- Able to build effective relationships at all levels both internally and externally and across organisational boundaries,
- Build and develop partnership working,
- Meet organisational priorities,
- Make sure staff understand their impact and the wider impact of pharmacy on patients,
- Able to solve problems in high-pressure situations,
- Able to analyse and interpret complex data and information to inform decisions,
- Demonstrates good decision-making skills that impact how pharmacy services are delivered,
- Adapts and innovates to meet the changing needs of patients and how pharmacy services are delivered,
- Keeps informed of developments in the pharmacy sector and applies any relevant learning to their organisation,
- Supports and facilitates a culture of research and innovation (within financial constraints),
- Provides clinical leadership in the procurement and management of medicines,
- Provides professional support and expert pharmacy advice to colleagues.

Standard 2: Develop a workforce with the right skills, knowledge, and experience.

To deliver high-quality, efficient, and safe pharmacy services with positive patient outcomes, it is essential to equip staff with the right skills, knowledge, and experience. As part of their overall responsibility, Chief Pharmacists must make sure that the pharmacy workforce receives the necessary development and training. They must also put succession planning in place.

Chief Pharmacists must:

- **Be aware of what skills, knowledge and experience are needed to deliver safe and effective pharmacy services in their setting,**
- **Optimise resources, and get the right skill mix in each team to deliver safe and effective pharmacy services,**
- **Support and value staff, consider their health and wellbeing,**
- **Create and maintain a culture of equality, diversity, and inclusion where people (including staff, patients, and the public), are treated as equals, with dignity and respect, and staff meet their own legal responsibilities under equality and human rights legislation, while respecting diversity and cultural differences,**
- **Make sure staff in their organisation know that they are the postholder,**
- **Inform staff that they can benefit from the defences provided certain conditions are satisfied,**
- **Promote a culture where staff feel safe to report errors and near misses and learn from them.**

Examples of how to meet this standard.

Below are examples of how Chief Pharmacists can meet this standard. It is not an exhaustive list and should be used as a prompt and not as a checklist:

- Be aware of the skill mix of each team, making sure that gaps are identified, and any necessary actions taken,
- Develop recruitment and retention strategies, as well as succession planning, to address any workforce or staffing issues,
- Maintain education and training plans that support the workforce in their ongoing development, including when innovation and new technologies are introduced,
- Encourage staff to work collaboratively, including as part of integrated and multi-disciplinary teams,
- Help protect the rights of individuals,
- Advance equal opportunity for staff, patients, and the wider public,
- Help improve the experience and healthcare outcomes of patients and members of the public using their organisation's pharmacy services,

- Embed organisational policies and procedures in team management practices, for example, around EDI (equality, diversity, and inclusion) training, such as cultural competence,
- Make sure systems are in place so that the workforce can provide feedback and suggestions, and contribute to the development and changes in the pharmacy service,
- Identify good practice and share with all relevant staff,
- Make sure staff have regular development reviews and any needs are addressed,
- Develop a culture where staff feel confident raising concerns, in line with the **duty of candour**, this is the professional responsibility to be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

Standard 3: Delegate responsibly and make sure there are clear lines of accountability.

Chief Pharmacists have wide-ranging responsibilities and often need to delegate to make sure that services are delivered safely and effectively; to make sure that this happens Chief Pharmacists must delegate responsibly. As senior leaders, when delegating, Chief Pharmacists are responsible and accountable for making sure the lines of accountability are clear. Details of delegation must be recorded, including who is responsible and accountable; this will reduce errors and foster a culture of transparency and accountability. Settings must make sure that if a Chief Pharmacist leaves the organisation, a replacement or an interim Chief Pharmacist must be in post so that pharmacy staff can continue to benefit from the defences.

Chief Pharmacists must:

- **Provide clarity about the roles, responsibilities, and accountabilities of the pharmacy workforce,**
- **Undertake appropriate risk assessments and only delegate to those who have the relevant skills, knowledge, and experience, and who are confident about assuming the additional responsibility,**
- **Communicate effectively and record delegation decisions accurately.**

Examples of how to meet this standard.

Below are examples of how Chief Pharmacists can meet this standard. It is not an exhaustive list and should be used as a prompt and not as a checklist:

- Able to successfully manage and mitigate clinical, safety, financial, and reputational risk,
- Make sure risk assessments are undertaken and that relevant staff are consulted/involved. Also need to make sure that assessments are reviewed as necessary, for example, if any changes take place,
- Allow staff to refuse a delegated task if they have good reason, for example, if they feel the task is outside of their scope of practice,
- Make sure staff are aware of their responsibilities, and the reporting structure.

Standard 4: Maintain and strengthen governance to ensure safe and effective delivery of pharmacy services.

Maintaining, strengthening, and establishing clear governance is a key component of the Chief Pharmacists' role. It involves several aspects, such as having arrangements for managing risks and oversight about how the pharmacy is managed and operated. To demonstrate this, Chief Pharmacists must communicate effectively at all levels and take a strategic approach when making decisions that affect how pharmacy services are delivered and organised.

Chief Pharmacists must:

- **Have oversight, and make sure that there is effective management of all pharmacy services and staff,**
- **Establish and communicate clear lines of reporting,**
- **Make sure that there is a mechanism to capture feedback including interventions, errors, and incidents, and they are reviewed regularly and appropriately managed.**

Examples of how to meet this standard.

Below are examples of how Chief Pharmacists can meet this standard. It is not an exhaustive list and should be used as a prompt and not as a checklist:

- Regularly review governance procedures, including Standard Operating Procedures (SOPs), and provide oversight of how the pharmacy is run and how services are delivered,
- Make sure necessary records are kept and maintained,
- Make sure that an effective records management system is in place, and that relevant staff are trained how to use it,
- Undertake robust performance measurement and reporting, and implement changes as necessary,
- Have oversight and input to the review and development of policies,
- Have mechanisms in place to anticipate, identify, and respond to risks,
- Make sure systems are in place to identify and report errors, including preparation and dispensing errors, and that errors are reviewed and appropriately managed,
- Internal and external complaints and concerns are reviewed regularly and are actioned,
- Plan and use resources effectively, considering any financial, audit and budgetary requirements.


Strategic and professional leadership
Developing the workforce
Standards for Chief Pharmacists
Delegation and accountability
Maintaining and strengthening governance

General Pharmaceutical Council

Appendix 2:

Chief Pharmacists: Draft consultation questions

Background

The Pharmacy (Preparation and Dispensing Errors – Hospital and Other Pharmacy Services) Order 2022, extends the defences from criminal prosecution arising in the event of inadvertent preparation and dispensing errors to pharmacy staff working in hospitals and other relevant pharmacy settings, such as care homes and prisons. The defences have been available to pharmacy staff working in registered pharmacies since 2018. The purpose of the Order is to ensure the same protection from prosecution applies to pharmacy staff working in a variety of different settings.

The Order amends the Medicines Act 1968 and introduces the conditions which must be satisfied for pharmacy staff to benefit from the defences. The first condition is that the pharmacy service must serve a facility where certain regulated activities are carried on. The legislation contains the full list of eligible pharmacy settings. Examples include hospitals, care homes, places where people are lawfully detained (such as prisons and pre-departure accommodation for people facing deportation) and other similar facilities. The second condition is that the pharmacy service must have a Chief Pharmacist (or equivalent role), in post.

Some of the requirements of the role of the Chief Pharmacist are specified in the Order. These include that the Chief Pharmacist must be a pharmacist who plays a significant role in making decisions about how the activities of the pharmacy services are managed or organised, or actually manages or organises those activities. The postholder must have the authority to make decisions about the running of the pharmacy service relating to the sale or supply of medicinal products and must be responsible for ensuring the pharmacy service is carried on safely and effectively.

The Order also made changes to our legislation, the **Pharmacy Order 2010**, so that we now have the power to further describe the responsibilities of Chief Pharmacists and to set professional standards of conduct and performance for postholders. Where an organisation chooses to have a Chief Pharmacist or equivalent role in post, the postholder is required to meet these standards. Failing to meet these standards may lead to us investigating concerns about a Chief Pharmacist's fitness to practise.

Below are the proposed standards that Chief Pharmacists must meet:

- **Provide strategic and professional leadership,**
- **Develop a workforce with the right skills, knowledge, and experience,**
- **Delegate responsibly and make sure there are clear lines of accountability,**

- **Maintain and strengthen governance to ensure safe and effective delivery of pharmacy services.**

Consultation questions

The Standards

1. **We have identified four standards for Chief Pharmacists. Do you think the standards will:**
    a. **strengthen and maintain pharmacy governance in the interests of patient safety?**

    Yes/No/Don't know

    b. **provide a governance framework which will support staff to:**

    i. report preparation and dispensing errors?

    Yes/No/Don't know

    ii. learn from those errors?

    Yes/No/Don't know

    Please explain your answers

    [Free text box]

2. **Thinking about the significance of the Chief Pharmacist role in making sure that pharmacy staff can benefit from the defences for preparation and dispensing errors, are there any other standards for Chief Pharmacists that you think are missing?**

    Yes/No/Don't know

    If yes, what are the standards you think should be included?

    [Free text box]

3. **The standards have been developed to apply to Chief Pharmacists regardless of the setting in which they work. Are there any settings where you think these standards could not be applied/met?**

    Yes/No/Don't know

    If yes, please identify the setting and why the standards could not be applied/met

    [Free text box]

Impact of the proposals

Impact on those sharing protected characteristics

We want to understand whether our proposals may have a positive or negative impact on any individuals or groups sharing any of the protected characteristics in the Equality Act 2010.

4. **Do you think our proposals will have a positive or negative impact on individuals or groups who share any of the protected characteristics?**

	Positive impact	Negative impact	Positive and negative impact	No impact	Don't know
Age					
Disability					
Gender reassignment					
Marriage and Civil partnership					
Pregnancy and maternity					
Race					
Religion or belief					
Sex					
Sexual orientation					

Please describe the individuals or groups concerned and the impact you think our proposals will have.
[Free text box]

Impact on other groups

We also want to know if our proposals will have an impact on other individuals or groups (not related to protected characteristics) - specifically, patients and the public, Chief Pharmacists, pharmacy owners/employers, pharmacy staff, other healthcare professionals and pharmacy students/pre-registration trainees.

5. **Do you think our proposals will have a positive or negative impact on any of these groups?**

	Positive impact	Negative impact	Positive and negative impact	No impact	Don't know
Patients and the public					
Chief Pharmacists					
Pharmacy owners/employers					

Pharmacy staff					
Other healthcare professionals					
Pharmacy students/pre-registration trainees					

Please describe the individuals or groups concerned and the impact you think our proposals will have.
[Free text box]

Any other comments

6. **Is there anything else related to the Chief Pharmacist standards that you would like to raise?**
[Free text box]

General Pharmaceutical Council

Advisory Group for post-registration assurance of practice

Meeting paper for Council on 07 December 2023

Public

Purpose

To provide Council with an update on the work of the Advisory Group for post-registration assurance of practice.

Recommendations

The council is asked to note and discuss the update.

1. Introduction

1.1 The Advisory Group for post-registration assurance of practice was established to provide advice for Council on what actions may be required to develop education and training, revalidation and annotation and governance/contractual frameworks in light of the rapidly developing roles and models in pharmacy and its increasing contribution to wider healthcare provision.

1.2 The previous update to Council on the work of the Advisory Group highlighted the work done to develop a clear set of principles to govern the work; the key elements of changing practice which has prompted the need to consider whether and how assurance needs to be developed and, in effect, to identify what the problem is that we need to solve. In short: How should assurance of post-registration practice be strengthened to take account of enhanced clinical practice, new models of delivery, rapidly changing roles and multiprofessional working across all pharmacy settings? Finally, the relevant levers of assurance that would be considered: education and training; revalidation and annotation; and governance and contractual frameworks.

2. Latest developments

2.1 The latest meetings have focused on insight into areas of risk; revalidation; and strengthening pharmacy governance.

Areas of risk

2.2 We have emphasised – in line with the principles agreed by the Group – that recommendations for Council need to reflect risks to patient safety. This is to ensure that

any strengthening of assurance is proportionate and focused. Based on initial work from inspections discussed with the Quality, Performance and Assurance Committee, the Group discussed three areas:

- **Governance**: the need for governance mechanisms to reflect the context of the setting – risks vary depending on model of delivery; volume; patients; training of staff. This becomes increasingly important as models of delivery and services provide change and develop.
- **Clinical governance:** the need for individuals to work within their scope of practice and having the skills, knowledge and confidence to understand when they are going beyond and/or where they feel pressured to go beyond. And the confidence to raise concerns. There is a link with more isolated working where limited peer involvement or senior direction is involved. Again, increasingly important as all pharmacists become prescribers and pharmacy technicians take on additional responsibilities.
- **Quality review:** the need for greater focus on this, taking into account rapidly developing services now and in coming years (e.g. prescribing), particularly where this happens in newer settings with less infrastructure and less opportunity for peer review.
- …and an overarching need for pharmacy professionals to understand how regulatory framework of professional standards and systems can help them to provide safe and effective care, moving between settings, multiprofessional teams and models of delivery.

Revalidation

2.3 In addressing areas of risk, the Advisory Group has considered some emerging developments to the current revalidation framework. There is broad support for the general requirements for planned and unplanned CPD; peer review and reflective accounts. But a strong consensus that these need to be developed further to realise the full benefits and provide the necessary level of assurance. There is also recognition that earlier evaluation of the current framework has been hampered by the pandemic, given the initial suspension and then partial resumption of revalidation to support the workforce at a time of huge pressure.

2.4 In terms of future development, the Group has noted the potential for more targeted requirements based on **role, level and scope of practice;** and the use of **themes –** such as EDI **–** on which all pharmacists and pharmacy technicians would be required to reflect on. We have also highlighted the need for more regular insight from revalidation to be collated and published to provide more assurance and to highlight areas for further development.

2.5 Alongside this initial thinking, the Group has provided some constructive feedback and challenge on how we might now evaluate the current framework to ensure any report contains forward-looking recommendations rather than simply assessing the 'as is' situation.

2.6 We are aiming to bring the policy development and evaluation strands together to produce a final set of recommendations in Autumn 2024 which will be considered by the Advisory Group prior to any decisions from Council.

Strengthening pharmacy governance

2.7 The Advisory Group provided useful input into an earlier draft of the Standards for Chief Pharmacists, which Council discussed at its last meeting and an updated version is also on the agenda today. A particular point highlighted by the Advisory Group was the benefit of including more explicit reference to cultural clinical competency and inclusive pharmacy.

3. Future meetings

3.1 In taking forward the programme of work for next year, we will be continuing to focus on revalidation, informed by our evaluation while, in parallel, developing policy proposals which will then come to Council. Based on the insight about areas of risk, we will also be focusing on those areas where current governance structures are less developed and where there is less opportunity for peer review and support. There is a particular need to clarify how newly-registered pharmacists in 2026 who will be qualified to prescribe will be supported and whether further governance arrangements are desirable at this stage. We will also utilise the skills and knowledge of the Advisory Group in relation to the work on strengthening pharmacy governance as, subject to DHSC proposals on supervision, we take forward work on new standards for Superintendent Pharmacists and Responsible Pharmacists, and new rules for Responsible Pharmacists.

3.2 With a clear focus for this group on both pharmacists and pharmacy technicians, we also want to ensure that the education and training requirements are considered for the roles that pharmacy technicians will be increasingly playing and what assurance may be necessary for pharmacists in advanced practice and consultant pharmacist roles. And, in a similar vein to the work on initial education and training, we need to ensure there is a shared understanding across health professions and healthcare regulators, and Governments, about how the increasingly clinical roles of pharmacists fit within wider healthcare delivery. registration.

4. Future updates

4.1 We will provide the next updates from the Post-Registration Assurance of Practice Advisory Group and the Initial Education and Training of Pharmacist Advisory Group at the meeting in April.

Recommendations

The council is asked to note and discuss the update.

Ann Jacklin, Aamer Safdar
Co-chairs post-registration assurance of practice Advisory Group

27/11/2023

General Pharmaceutical Council

Closure of the temporary register

Meeting paper for Council on 07 December 2023

Public

Purpose

To update Council on the closure of the temporary register on 31 March 2024 and the actions being taken ahead of this.

Recommendations

Council is asked to note the update.

1. Introduction

1.1 The GPhC temporary register was set up in March 2020 after the Secretary of State for Health and Social Care asked us to use our emergency powers in the Pharmacy Order 2010 to register fit, proper and suitably experienced persons assist in the national response to COVID-19. Similar requests were made to other healthcare regulators.

1.2 We therefore placed pharmacists and pharmacy technicians on the temporary register where they:

(a) came off the register no more than three years previously;

(b) were removed from the register due to voluntary removal, or non-renewal of registration;

(c) had no live fitness to practise issues.

1.3 This resulted in around 6,000 pharmacists and pharmacy technicians being temporarily registered and available to assist the healthcare workforce during the pandemic.

1.4 The Secretary of State subsequently asked healthcare regulators to keep their temporary registers open until September 2024 to assist with ongoing efforts to address Covid-related backlogs and further pressures. This was done with revised criteria agreed by Council to ensure that those on the temporary register were working or intending to work; and requiring them to produce a reflective account demonstrating how they were meeting our standards; and to make a declaration in relation to fitness to practise and indemnity arrangements. This resulted in a significant reduction in the number of people temporarily registered and, as of 15 November 2023, there are 84 pharmacists and 34 pharmacy technicians on the temporary register.

2. Request to close the temporary register

2.1 On 11 September 2023, the Minister of State for Health and Social Care wrote to the General Pharmaceutical Council asking us to close our temporary register on 31 March 2024, rather than 30 September 2024, as had previously been requested. The health minister wrote in the same vein to other health regulators.

2.2 The rationale was the government's expectation that the emergency conditions required for the utilisation of temporary registers would no longer apply after the winter of 2023.

2.3 Therefore, the government wished to keep healthcare temporary registers open until 31 March 2024 to address any winter pressures, and to allow time for healthcare professionals who wished to re-join their respective full register to do so ahead of the closure.

3. Communications

3.1 Having received the letter from the health minister, we put in place a communications plan to:

(a) effectively engage and inform all relevant stakeholders about the closure of the temporary register at the end of March 2024;

(b) communicate a deadline of 16 February 2024 for applications to join or re-join the temporary register, while the temporary register is still active;

(c) encourage pharmacists and pharmacy technicians to join the full register and set out how to do so.

3.2 To provide for potential cover in response to winter pressures due to a new Covid variant, we have kept open the option of joining or re-joining the temporary register until six weeks before the temporary register closes.

3.3 We sent an email to pharmacists and pharmacy technicians on the temporary register on 22 September 2023, to let them know about the forthcoming closure of the temporary register, and how they might re-join the full register.

3.4 We sent an email to pharmacy sector employers on 18 October 2023 to let them know about the forthcoming closure of the temporary register, and to remind them of their obligations if they were employing someone who is registered on a temporary basis. For example, that the temporarily registered pharmacy professional must be working within their level of competence and have appropriate insurance arrangements in place.

3.5 We have scheduled further reminders for both pharmacists and pharmacy technicians and employers, in late November 2023, mid-January 2024 and early March 2024.

4. Equality and diversity implications

4.1 None arising from this.

5. Resources

5.1 No additional resource implications.

6. Risk implications

6.1 The main risk is individuals remaining on the temporary register after its closure on 31 March 2024 and thereby continuing to practise when they are not permitted to do so. The

communications outlined above are designed to mitigate this risk and we will also use our ongoing engagement with employers to ensure they are fully aware.

Recommendations

Council is asked to note the update.

Mark Voce, Director of Education and Standards
General Pharmaceutical Council

27/11/2023

General Pharmaceutical Council

Assurance and Appointment Committee (AAC) Annual Report

Meeting paper for Council on 07 December 2023

Public

Purpose

To present to Council the AAC Annual Report which sets out the Committee's work over the past year.

Recommendations

That Council notes the contents of the AAC Annual Report at Appendix 1.

1. Introduction

1.1 Council established the independent Appointments Committee - now referred to as the Assurance and Appointments Committee (AAC) - to recruit, appoint and performance manage the members of its statutory committees: the Investigating Committee (IC), the Fitness to Practise Committee (FtPC) and the Registration Appeals Committee (RAC).

1.2 The AAC has a duty to report to Council annually on its work. It last produced an Annual Report for the Council to cover the period of mid-2020 to mid-2022, a Report that was written against the backdrop of the global pandemic. As we all move to post-Covid working – with Investigating Committees now meeting remotely as the norm and Fitness to Practisce Committees meeting both remotely and in person - this Report covers a twelve-month period and seeks to provide the Council with both a comprehensive overview of the work, focus and effectiveness of the Committee, along with an indicative forward look and a consideration of what will and is being prioritised in 20223/24.

1.3 The attached report sets out how the Assurance and Appointments Committee is delivering against each of its key workstreams. In keeping with previous reports important information on monitoring and reporting back on diversity figures is also included. This commitment remains absolutely at the heart of the Committee's work.

1.4 The Report is appended at appendix 1.

2. Equality and diversity implications

2.1 As is demonstrated within the Report itself, Equality, Diversity and Inclusion (EDI) is at the heart of work of the AAC. Specifically, EDI considerations have driven the Committee's approach to the most recent Statutory Committee recruitment exercise (currently in

progress) having reviewed role descriptions, adverts and communications as part of efforts to attract a diverse range of candidates for statutory committee vacancies.

3. Risk implications

3.1 Assurance statement: I feel well placed to provide the Council with assurance that the work of the Assurance and Appointments Committee and my own work as Chair - with the responsibility for quality assurance and performance management of the individuals which that involves - is operating well procedurally, is aligned with the Council's values and reinforces its commitment to maintaining public confidence in the profession.

4. Recommendations

That Council notes the contents of the AAC Annual Report at Appendix 1.

Elisabeth Davies, Chair of the Assurance and Appointments Committee

02/11/2023

General Pharmaceutical Council

Assurance and Appointments Committee Annual Report 2022/23

1. About this report

1.1 The Assurance and Appointments Committee has a duty to report to Council annually on its work. It last produced an Annual Report for the Council to cover the period of mid-2020 to mid-2022, a Report that was written against the backdrop of the global pandemic. As we all move to post-Covid working – with Investigating Committees now meeting remotely as the norm and Fitness to Practise Committees meeting both remotely and in person - this Report covers a twelve-month period and seeks to provide the Council with both a comprehensive overview of the work, focus and effectiveness of the Committee, along with an indicative forward look and a consideration of what will and is being prioritised in 2023/24.

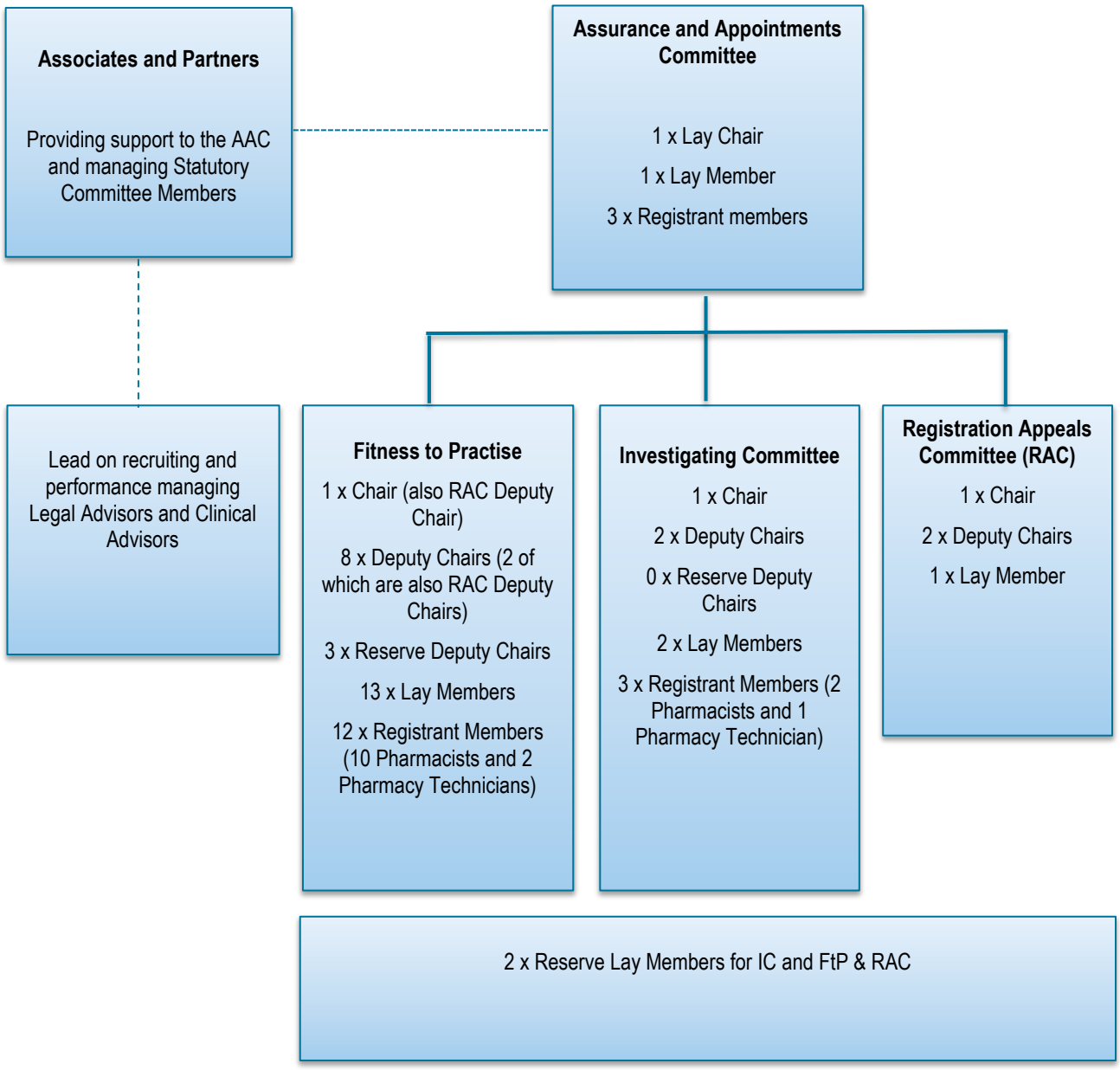
1.2 This report is written against the backdrop of:

- A strengthened Associates & Partners function within the GPhC which is providing more operational support (eg. Around supporting the recruitment of new Statutory Committee Members in 2023) alongside more strategic support (eg. Driving forward consideration of the GPhC's approach to quality assurance more generally and where and how the AAC fits within this.)
- The change from a Deputy Chair to Lay member of the AAC which was previously agreed by the Council of the GPhC.
- The impact of the introduction of two new members within the AAC who have brought new skills and experiences, alongside the loss of two longer standing members.
- Changes to the GPhC's Executive Team structure.
- The focus on timeliness and meeting PSA oversight regulatory requirements.

Introduction

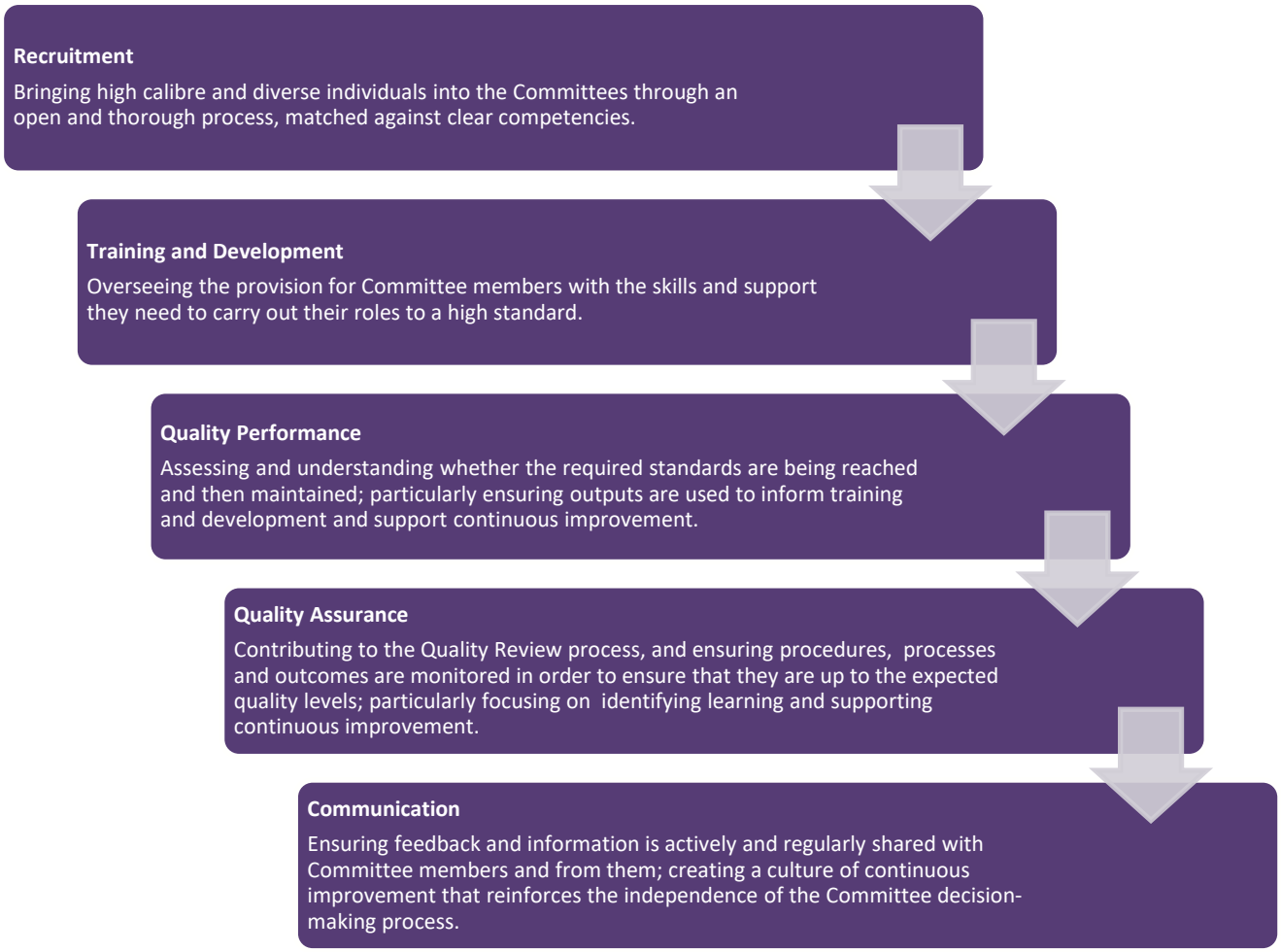
1.3 The Council established the independent Appointments Committee – now referred to as the Assurance and Appointments Committee (AAC) – to recruit, appoint and performance manage the members of its statutory committees: the Investigating Committee (IC), the Fitness to Practise Committee (FTPC) and the Registration Appeals Committee (RAC). The figure below sets out the numbers of SCMs currently recruited, trained and appraised by the AAC (you can read more about

how the Committee is responding to evolving and changing requirements around the number of SCMs required by the GPhC later in this Report).



1.4 The Assurance and Appointments Committee articulates its work on the basis of five workstreams (see below). Accordingly, for each of the five workstreams this Report provides information on (i) the process or what the Assurance and Appointments Committee does; ii) particular outcomes or

results for 2022/23; and (iii) plans and priorities for 2023/24. This three-way approach is in recognition of the importance and value of sharing actual outcomes – conclusions that can be drawn from the data and processes – along with providing the Council with an indication of the AAC plans and intentions for the upcoming year.



3. About the AAC

3.1 The AAC operates as an independent Committee of the GPhC. It is responsible for delivering its five workstreams and ultimately in overseeing the delivery of Investigating Committee (IC) meetings and Fitness to Practice Committee (FtPC) hearings that are efficient, effective and clearly separate from the investigatory role of the General Pharmaceutical Council.

3.2 The AAC is not made up of GPhC Council members or staff, nor is it made up of Statutory Committee members (SCMs) who form the Investigating Committee (IC) and the Fitness to Practise Committee (FtPC). Rather it is made up of five independent members, three of whom are registrants of the GPhC and two of whom are lay (including the Chair). They meet four times a year and the current members of the Committee are:

Elisabeth Davies (Chair)

Kathryn Foreman (Lay member)

Ahmed Aboo (Pharmacist registrant member)

Rebecca Chamberlain (Pharmacy technician registrant member)

Karen Hong (Pharmacist registrant member).

3.3 In order to carry out its role effectively the AAC is dependent on close working relationships with the GPhC staff, but relationships that respect its ability to bridge the independence of the SCMs with the investigatory role of the GPhC. It does this pre-dominantly through being ably supported by the Associates & Partners Team. Working alongside the Hearings function within Adjudication Services, this Team is well placed to enable the AAC to establish a culture of continuous improvement and learning across the SCMs.

3.4 The AAC operates according to good governance recommendations and carried out a Committee Effectiveness Review in September 2023. The highlighted strengths included the degree of independence established from the GPhC; its high ambitions when it comes to its focus on diversity; its willingness to evolve; and the precision of its work. Further consideration is needed on how the Committee focuses on quality, including more information on how Statutory Committee Members (SCMs) benchmark against standards. You can read more about the Committee's plans to respond to the findings of its Effectiveness Review in this Report as these commitments have been factored into its priorities for 2023/24.

Executive Summary

Workstream One: Recruitment

4.1 Throughout the last year the AAC has continued to focus on the number of SCMs required. A recruitment plan has been agreed and developed for both 2023 and 2024 with appointments taking place at the end of 2023. The AAC has worked closely with the GPhC's EDI Team and this has included a whole process review, looking at the end-to-end process, and revisiting member role descriptions as well as recruitment channels. Consideration has also been given to the scope for appealing to more development candidates who are likely to be at different stages of their careers, along with ensuring recruitment takes place under the steer of disability confident guidance. As a result, the focus of the 2023 recruitment round has been on ensuring the

recruitment campaign also appeals to those who don't necessarily have experience of the tribunal or regulatory hearing process, as well as more experienced candidates.

Workstream Two: Training and Development

4.2 In October 2022 refresher training was run for all SCMs and included sessions on online pharmacy provision (a very current topic for members) and remote hearings. The planned training on Islamophobia (there were calls for training in this area from members following on from the Antisemitism training the previous year) was unfortunately postponed due to challenges of sourcing the right trainer but it is now scheduled to take place with sessions in February 2024 and March 2024.

4.3 The training plan for 23/24 will combine remote and in person training sessions. It will include sessions on Interim Orders, Conditions, and Assessing Evidence.

Workstream Three: Quality performance

4.4 Performance messages clearly emerge from the appraisal process with clear themes present around:

- The amount of preparation time put in and the dependence on this for the smooth running of Committee meetings and hearings (NB. This has been taken account of by the GPhC this year in its revised fee structure).
- The intellectual challenge of the role and the need to remain on top of GPhC policy and guidance.
- The need to embrace person-centred regulation, treading a careful line between empathy and losing impartiality.

4.5 In 23/24 particular attention is being paid to increasing the feedback provided after each meeting on each Deputy Chair and SCM. This is an essential part of each annual review process, but current rates are not what they should be. The AAC is looking at how feedback rates can be improved.

Workstream Four: Quality assurance

4.6 Key themes raised by statutory committee members via QRG part two have continued to include:

- How sexual behaviour is reported by the Council.
- How case management directions are handled.
- Quality and consistency of redactions (e.g. background information being included which could prejudice a decision).

4.7 In addition, QRG part two provides a vital route to highlight quality issues from QRG part one with the Chair of AAC and which are then fed back at either an individual level and/or might inform the annual training and development plan. IC processes have remained high on the agenda this year.

4.8 Another substantial focus of this year has been on the GPhC's wider review of the QRG process, recognising its role as part of the GPhC's quality assurance framework. Recommendations will be implemented in 2023/24 based on three types of QRG: Administrative and Procedural Review Group; Decision Review Group and Thematic Review Group. The three new groups will effectively replace QRG part one and QRG part two meetings.

Workstream Five: Communications

4.9 The most significant communications development in recent years has been the introduction of the GPhC's new online portal. This continues to work well, enabling SCMs to access GPhC policies and procedures, guidance and relevant case law, all in one place, as well as then providing a single point of access for fee enquiries and the submission of invoices. Importantly it also provides a secure space for the sharing of case papers with only the Committee Members hearing a case having access to the papers for that case.

4.10 The AAC will support the GPhC as it works through the next steps of implementing the online portal. It will also continue to make best use of the Members newsletter sent out by the Adjudications Team, providing a Chair's introduction and overview for each edition.

Equality, Diversity and Inclusion

5.1 In terms of overall diversity of the SCMs, the data highlights:

- Over half (57%) of committee members are female.
- In spite of the female majority overall the percentage of male Chairs is higher (53%).
- The breakdown of 17% according to disability is on a par with the 2021 CENSUS results (18%).

5.2 In 2023/24 consideration continues to be given to EDI in the context of the regulatory journey. The Associates & Partners function is running an anonymisation project with the Investigating Committee. The main objectives of the project are to give procedural confidence and assurance to registrants of the fairness of a process involving anonymisation (analogous to the assurance given to applicants in anonymised HR processes).

5.3 The AAC is, as always, aware that more needs to be done to attract high calibre applicants from underrepresented groups. Accordingly, plans for the next recruitment campaign have been taken forward entirely consistently with the GPhC's EDI strategy and have been designed to attract applicants from as diverse a range of backgrounds and sections of the community as possible. Recruitment plans have prioritised EDI and have included an end-to-end journey review that takes account of a revised role description and competencies, alongside revised support and induction packages, which could allow for more 'development' candidates to be appointed.

General Pharmaceutical Council

4 Workstream One: Recruitment

What we do

6.1 It is essential that the AAC brings high calibre and diverse individuals into the committees through an open and thorough process.

6.2 A key element of the AAC's role is to ensure that there is accurate matching between the GPhC's forecasting of numbers of likely committee meetings and hearings in the future, with the number of SCMs required.

Outcomes for 22/23

6.3 Throughout the last year the AAC has focused on working with the Adjudications Team in overseeing improvements in hearings forecasting, Statutory Committee feedback completion and Statutory Committee recruitment.

6.4 Planning for recruitment in the Autumn of 2023 and the Spring of 2024, the AAC has worked closely with the GPhC's EDI team. This has included a whole process review, looking at the end-to-end process, and taking account of revisiting member role descriptions as well as recruitment channels. Consideration has also been given to the scope for appealing to more development candidates who are likely to be at different stages of their careers, along with ensuring recruitment takes place under the steer of disability confident guidance.

6.5 As a result, the focus of the 2023 recruitment round has been on appealing to those who don't necessarily have pre-existing experience of the tribunal or regulatory hearing process.

Plans for 23/24

6.6 This will focus on delivering on the pre-existing and agreed recruitment plan and will also entail revisiting the numbers required in the light of the Fitness to Practise Programme for achieving Standard 15. There will be an opportunity to run a general learning exercise from this year and to make any changes as a result.

6.7 An enhanced induction programme is being planned, recognising that some of those who will be joining at the end of 2023 may not be able to 'hit the ground running' and may therefore require additional support. The induction will look at the hard skills required to do the role along with the behaviours. A number of existing Deputy Chairs are set to contribute, particularly their thoughts on collective decision making.

General Pharmaceutical Council

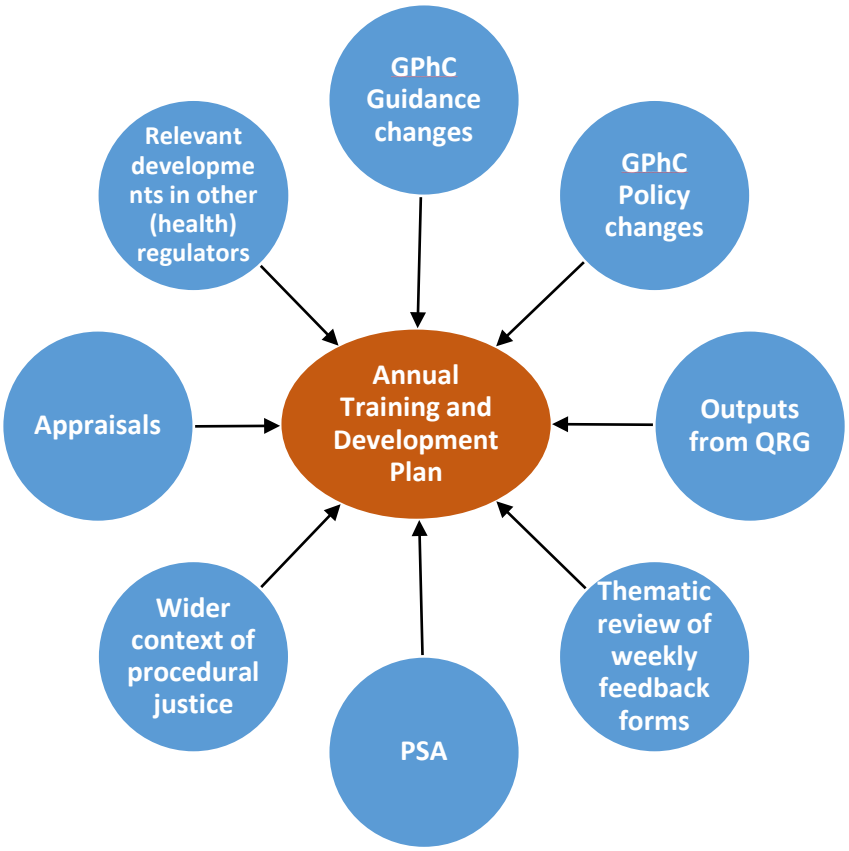
7 Workstream Two: Training and development

What we do

7.1 The AAC is responsible for providing committee members with the skills and support they need to carry out their roles to a high standard.

7.2 The annual training and development plan is developed in line with GPhC policy changes, GPhC guidance changes and the wider context of regulatory and procedural justice, including relevant PSA developments. It is informed by the feedback from committee members themselves along with what is coming out of the rolling appraisal process and the wider quality assurance approach, including the work of the Council's Quality Review Group (QRG).

7.3 The training and development plan covers regular refresher training for the entire membership cohort, as well as considering the specific training needs of Investigating Committee members as distinct to Fitness to Practice Committee members.



Outcomes for 22/23

7.4 The following training and development took place in 2022/23:

DATE	ATTENDEES	Attendance	TOPIC/ ISSUES
April 2022	IC Chairs	100% attendance	Remote meeting of IC Chairs which included: • IC Process Review evaluation • Review of QRG process • Adjourned warnings
June 2022	IC and FtP Deputy Chairs	10 out of 15 Deputy Chairs	Remote meeting of All Chairs which included: • Determination templates and support for this • Hearings data • Committee member recruitment plans and implications for Deputy Chairs
November 2022	Annual refresher training of all FtP and IC members and Deputy Chairs	100%	Remote training which included: • Guidance on Remote Hearings • Online Pharmacy
November 2022	IC and FtP Deputy Chairs	10 out of 15 Deputy Chairs	Hybrid meeting of Deputy Chairs which included: • Hearings Format Guidance • Decision Making Style/Guidance • IC Anonymisation Update • Chair Practise Directions

DATE	ATTENDEES	Attendance	TOPIC/ ISSUES
December 2022	IC Chairs	100%	Remote meeting of IC Chairs which included: • IC Statistics and Future Membership numbers of IC • Quality issues and IC • IC process and Template Review Evaluation • Anonymisation Project • Redactions
March 2023	IC and FtP Deputy Chairs	5 out of 15 Deputy Chairs	Remote meeting of Deputy Chairs which included: • Accommodation Update • Committee Recruitment Plan • Decision Making Style/Guidance

7.5 Detailed participant feedback is collected from all attendees for every training session and has generally been very positive. Examples of feedback received regarding the Annual Refresher training in 2022 include:

> *"Leslie is a great trainer. His sessions are always highly relevant and engaging. He gave some really great practical advice and tips, which I always find the most useful aspect of training. Being able to learn from the experience of others is really important."*
>
> *"(I) would have liked more specific case studies on some FTP cases and outcomes. This is a new but rapidly growing area. Some of us had done a couple of cases but some had done none."*
>
> *"I found the setting out of the legal framework and guidance very helpful. I also found the contributions by the GPhC senior clinical expert really interesting on the issues that can arise in online pharmacy."*

7.6 Regular Chairs' meetings – now three a year - are held for the Deputy Chairs. These provide safe space, allowing them to share information on cases, case management and procedure, and to make suggestions to improve process. The AAC Chair and relevant GPhC staff attend for all or part of these meetings. The meetings are not compulsory so not all Deputy Chairs are able to attend all meetings but the agenda, papers and minutes are circulated amongst all Deputy Chairs and some who are not able to attend often contribute by emailing their thoughts in advance of meetings.

7.7 These meetings are Chaired by the overall 'Chair of Chairs' or the single Fitness to Practice Committee Chair (all others are technically Deputy Chairs). The current Chair is Philip Geering, and his role is also to act as a mentor to the Deputy Chairs, providing ad hoc support as required and feeding issues back to the GPhC and the Chair of the Assurance and Appointments Committee as necessary. In Chairing the meetings of Deputy Chairs, Philip is charged with addressing collective consistency issues, exploring questions of policy/procedure; and receiving training/updates e.g., policy updates, case law, issues identified via review of determinations etc. An equivalent role specifically for IC Deputy Chairs is carried out by Jill Crawford, the Chair of the Investigating Committee.

7.8 Throughout the year EDI has remained a core theme within, and influence on, the training plan. The Deputy Chairs have received regular updates on the GPhC's EDI Strategy. Following on from last year's successful delivery of a session on Antisemitism as part of the Annual Refresher training, it had been planned to include sessions on Islamophobia. This was unfortunately postponed due to challenges in sourcing a trainer to deliver a bespoke set of sessions but is now back on track and plans are being developed to run this for SCMs and for GPhC staff.

Plans for 23/24

7.9 The training plan for 23/24 will combine remote and in-person sessions. Members were surveyed to assess the demand for training to take place in-person. The result was clear that over half of Members wanted an in-person option for training whilst others preferred training to take place remotely. In response to those results, it is proposed to run the same training both in-person and remotely in 2023. The training topics planned are:

- Interim Orders - Training in this area has been proposed in response to work undertaken by Fitness to Practise regarding Interim Order (IO) templates, and issues that have arisen in QRG referrals including the adjournment of an IO application.
- Conditions - A new Conditions Bank has been launched so this subject will be topical in the run up to the training dates.
- Assessing Evidence - The idea for this session has originated in discussion with Members and is identified as a core skill which is of relevance to both FtPC and IC Members alike.
- Islamophobia - There were calls for training in this area from members following on from the Antisemitism training previously held. GPhC's EDI Team is supportive of the training proposed in this area.

7.10 In addition to plans for the training session, this will be supplemented by a series of timely guidance notes and resources. For example, Trans Rights is clearly a complex subject and a case with these issues has already been considered by another regulator. A number of members have asked for more information and guidance on this topic.

General Pharmaceutical Council

8 Workstream Three: Quality performance

What we do

8.1 Assessing and understanding whether the required standards are being reached, and then maintained, is at the heart of the Assurance and Appointment Committee's approach to performance monitoring.

8.2 Feedback on committee member performance is gathered by a variety of means. Online feedback forms are completed by chairs, members and the secretariat for each hearing or meeting. These are useful for ascertaining themes such as timeliness and quality of case preparation, as well as more specific issues.

8.3 In addition, a protocol determines whether any concerns raised are dealt with at the time by a Deputy Chair, staff, included in the annual performance review information or passed to the AAC Chair. If immediate action needs to be taken to raise a matter with a Deputy Chair or Member, the AAC Chair will make a phone call or arrange a meeting for discussion

8.4 As part of performance management, and as a reflection of the AAC's focus on ongoing improvement, the AAC Chair reviews the performance of Chairs and Deputy Chairs annually in a formal performance review meeting. The Deputy Chairs in turn review the performance of the Members. Prior to the review meeting the AAC Chair observes the Chair/Deputy Chair at a hearing and reviews feedback gathered through the year from online hearing/meeting feedback forms. This feedback is also shared with the Deputy Chairs. Those being reviewed are asked to complete self-appraisal forms. These meetings provide an opportunity to reflect on the work, to identify training needs and to appreciate the work undertaken.

Outcomes for 22/23

8.5 Performance messages clearly emerge from the appraisal process with clear themes present around:

- The amount of preparation time put in and the dependence on this for the smooth running of Committee meetings and hearings (NB. This has been taken account of by the GPhC this year in its revised fee structure).
- The intellectual challenge of the role and the need to remain on top of the GPhC policy and guidance.
- The need to embrace person-centred regulation, treading a careful line between empathy and losing impartiality.

8.6 Key learning points captured by the reviews include:

- Online pharmacy remains an area where members are potentially calling for more information and it will be important for the AAC to keep a close eye on this.

- A greater focus on the use of templated approach to the drafting of determinations by Deputy Chairs. These will need to be in place when the new Deputy Chairs are recruited in 2024.
- The blend of in person and remote working for FtP members is now well established and is working well. Deputy Chairs and members are aware of potential differences for new members who they may never have met in person and whether this could create any new challenges for collective decision making.

8.7 It is essential that all SCMs and the AAC continue to hold themselves to account and are open to continuous improvement and learning. No complaints were received during the lifetime of this Report, either in relation to the behaviour of individual SCMs or the work of the AAC.

Plans for 23/24

8.8 The Annual Performance Review process will continue to be rolled out and improved as required.

8.9 Focus and consideration has started to be given this year to improving feedback rates. These are currently at around 40% of what they could be, Whilst the GPhC's approach to, and commitment to gathering feedback is praised by the other regulators, further work is need on improving feedback rates.

Workstream Four: Quality Assurance

What we do

9.1 The Assurance and Appointments Committee monitors procedures, processes and outcomes in order to ensure that they are up to the expected levels of quality standards. This is a key part of our commitment to identifying learning and supporting continuous improvement.

9.2 The GPhC's Quality Review Group, and in particular the part two meetings, is an important element in the AAC's approach to quality assurance. Given that part two meetings of the Quality Review Group have now been taking place for over five years it has therefore been right that this year the QRG process has been reviewed in its entirety. Recommendations have been agreed and the next year is set to be a time of transition from old to new.

Outcomes for 22/23

10.1 The Assurance and Appointments Committee regularly reviews a summary of the key QRG part two issues. These are also frequently shared with members via the regular newsletter.

10.2 Key themes raised by statutory committee members via QRG part two have included:

- How sexual behvavour is reported by the Council.

- How case management directions are handled.
- Quality and consistency of redactions (e.g. background information being included which could prejudice a decision).

10.3 Sufficiency of explanation and reasoning in IC decisions has continued to be a key message coming through the QRG part two process. More detailed feedback has therefore been shared with the IC Deputy Chairs as a group, allowing a concerted focus on:

- The role of the IC and Rule 6 of the Fitness to Practise and Disqualification etc Rules 2010.
- Health and Misconduct
- Mental health, dependency and dishonesty
- IC and Interim Orders

10.4 A significant area of focus in 2022/23 has continued to be the IC process review, and its subsequent evaluation. QRG part two commissioned a process review of the Investigating Committee (IC) at its meeting in January 2020. A review was undertaken, and several recommendations were implemented from August 2020 including the introduction of a decision template.

10.5 Upon implementation it was planned that an evaluation would be carried out on the changes implemented. The evaluation comprised two main components: A survey of IC Members and an assessment of a random sample of IC decisions since implementation of the decision template. Key messages from the evaluation have continued to be adopted this year including: Positive feedback on the introduction of the decision template (which is accordingly now being considered for the FtPC process); the reduction in the size of the IC has been followed in September 2022 when member contracts came to an end and were not renewed; all meetings have continued to be held remotely.

Plans for 23/24

10.6 The focus will be on implementing the review of the new QRG process, particularly how the AAC can best support the move to the three new groups: Administrative and Procedural Review Group; Decision Review Group and Thematic Review Group.

10.7 Alongside this the AAC will continue to support the development of the Executive Team function at GPhC including the wider focus on QA processes and AAC's role within this.

General Pharmaceutical Council

9. Workstream Five: Communications

What we do

11.1 Ensuring feedback and information is actively and regularly shared with committee members, and from them, is an essential part of the work of the Assurance and Appointments Committee. Maintaining the independence of the Committee decision-making process is entirely compatible with sharing information and learning.

11.2 A regular newsletter is the main channel of communication with all members, updating them on GPhC and wider healthcare regulatory policy, emerging case law and thematic feedback.

Outcomes for 22/23

11.3 Following the introduction last year of the GPhC's new online portal, work has continued this year on ensuring this is working effectively and is being well used. There have been limited concerns raised with the portal. It successfully enables SCMs to access GPhC policies and procedures, guidance and relevant case law all in one place as well as then providing a single point of access for fee enquiries and the submission of invoices. Importantly it also provides a secure space for the sharing of case papers, avoiding the need for sending multiple password-protected papers via Egress switch.

11.4 An SCM fee review has also been successfully carried out by the A&P Team this year. This has been well received with the subsequent increase in fee marking a clear recognition of the preparation time expected to be put in.

11.5 In addition, the AAC Chair corresponds with members regularly, and observes as many hearings as possible, which, as well as allowing her to monitor performance, provides a welcome opportunity to catch up with panellists and listen to their feedback and any concerns.

Plans for 23/24

11.6 The AAC will support the GPhC as it works through any further next steps of introducing the online portal.

11.7 It will continue to make best use of the regular newsletter, including through providing a Chair's introduction and overview.

10. Equality, Diversity and Inclusion

12.1 The statutory committees strive to promote and reflect equality, diversity and inclusion when performing their regulatory functions. The Assurance and Appointments Committee and the scheduling staff try to ensure that the people appointed and allocated to the statutory committees reflect the diversity of the public they serve and the registrant population.

12.2 This year's diversity statistics for the current committees can be found at Appendix 1. This information has been taken from the portal, whereby the members have been asked to complete the EDI form. This is a different process to that adopted in previous years.

12.3 Benchmarking statistics are taken from the 2021 CENSUS and the registrant population figures are taken from the GPhC's registers.

12.4 The combined data highlights the following key points:

- Over half (57%) of committee members are female.
- In spite of the female majority overall the percentage of male Chairs is higher (53%).
- The breakdown of 17% according to disability is on a par with the 2021 CENSUS results (18%).

12.5 The AAC is, as always, aware that more needs to done to attract high calibre applicants from underrepresented groups. Accordingly, plans for the current recruitment campaign have been taken forward entirely consistently with the GPhC's EDI strategy and have been designed to attract applicants from as diverse a range of backgrounds and sections of the community as possible. However, the AAC is also very aware that equality, diversity and inclusiveness is about more than the recruitment process followed. Recruitment plans prioritising EDI have included an end-to-end journey review that has taken account of revised role description and competencies, alongside revised support and induction packages, which could allow for more 'development' candidates to be appointed.

12.6 In addition, following a decision last year the AAC is benchmarking lay members against the UK population CENSUS 2021 figures whilst registrant members are being benchmarked against the GPhC's registrant population. This is reflected in this Annual Report.

12.7 Finally, consideration continues to be given to EDI in the context of the regulatory journey. The Associates & Partners function is now running an anonymisation project with the Investigating Committee. The Investigating Committee (IC) process was chosen as the IC assess cases on papers only so this process lends itself well to a project involving redaction. The project involves the redaction of information which might identify the ethnicity of the registrant before the case

papers are considered by the IC.

12.8 The main objectives of the project are: Enhancing confidence in the fairness of the Investigating Committee process; collecting detailed outcome data according to Ethnicity and Nationality from the Investigating Committee process; evaluating the impact of using anonymisation in the Investigating Committee process.

12.9 An analysis of the project will commence around January 2024. At this stage the anonymisation of cases will have been running for 12 months and there will be sufficient data to draw conclusions as to the extent to which objectives have been and are being met.

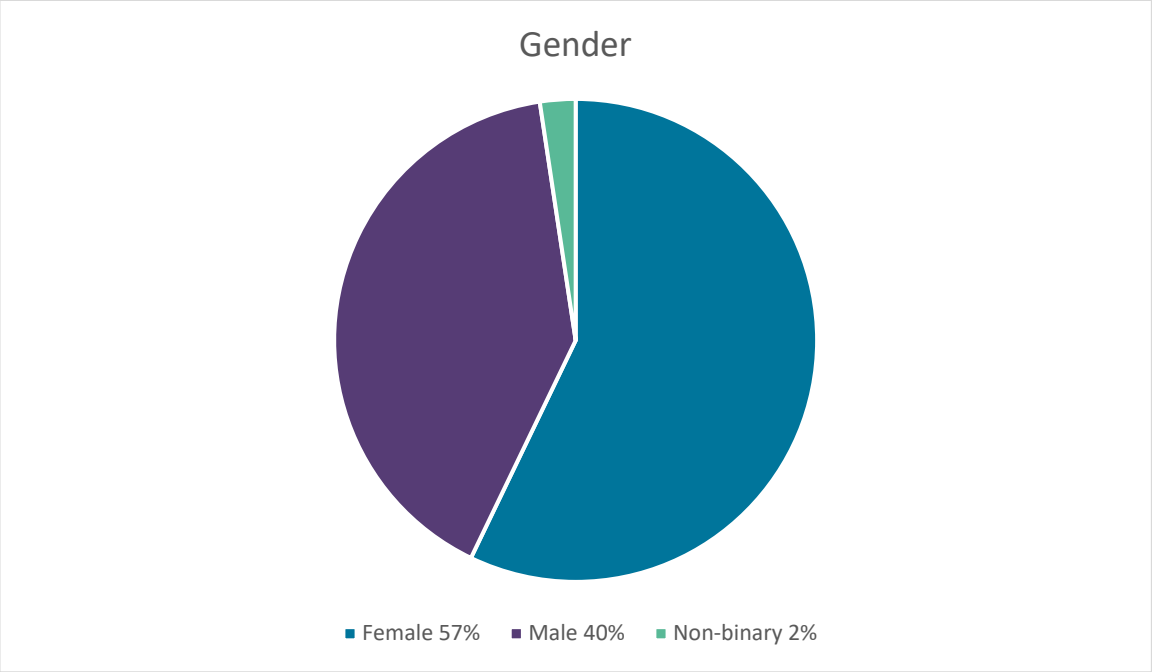
General Pharmaceutical Council

Assurance and Appointments Committee Annual Report 2022/23

Appendix 1

The tables and information below provide an EDI breakdown of the two Statutory Committees, Investigating Committee and Fitness to Practise. This information has been taken from the portal, whereby the members have been asked to complete the EDI form.

Gender

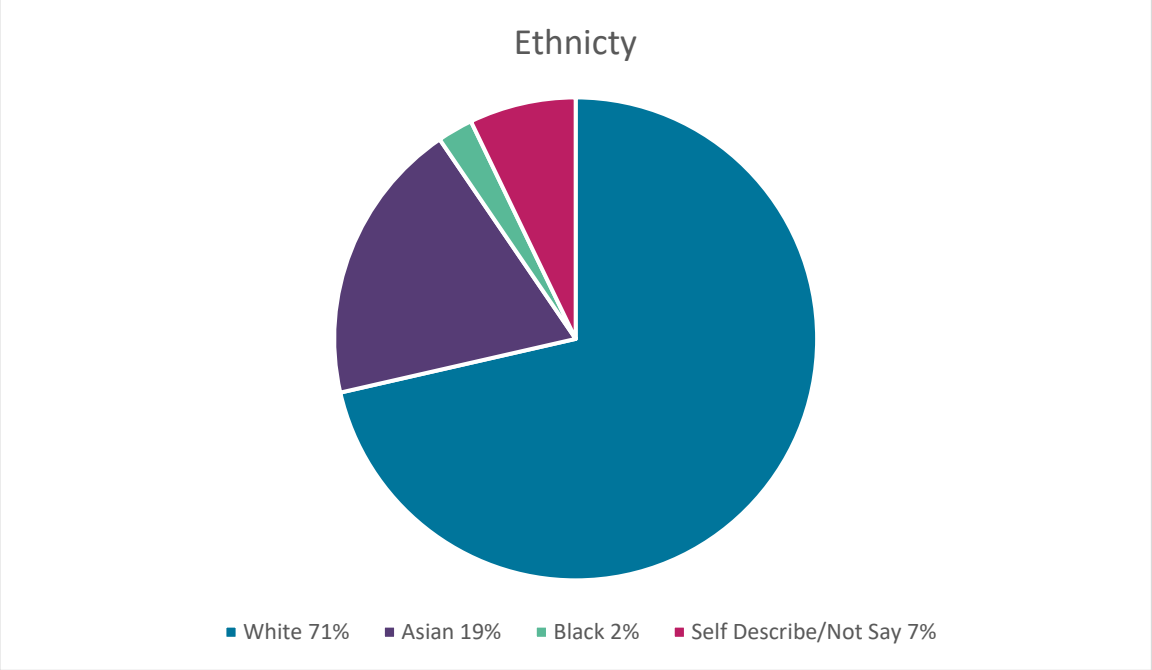


Gender of Chairs/Deputy Chairs

Whilst the majority of Committee Members are female (57%) the percentage of female Chairs is 47% as against 53% who are male.

General Pharmaceutical Council

Overall Committee Member Ethnicity



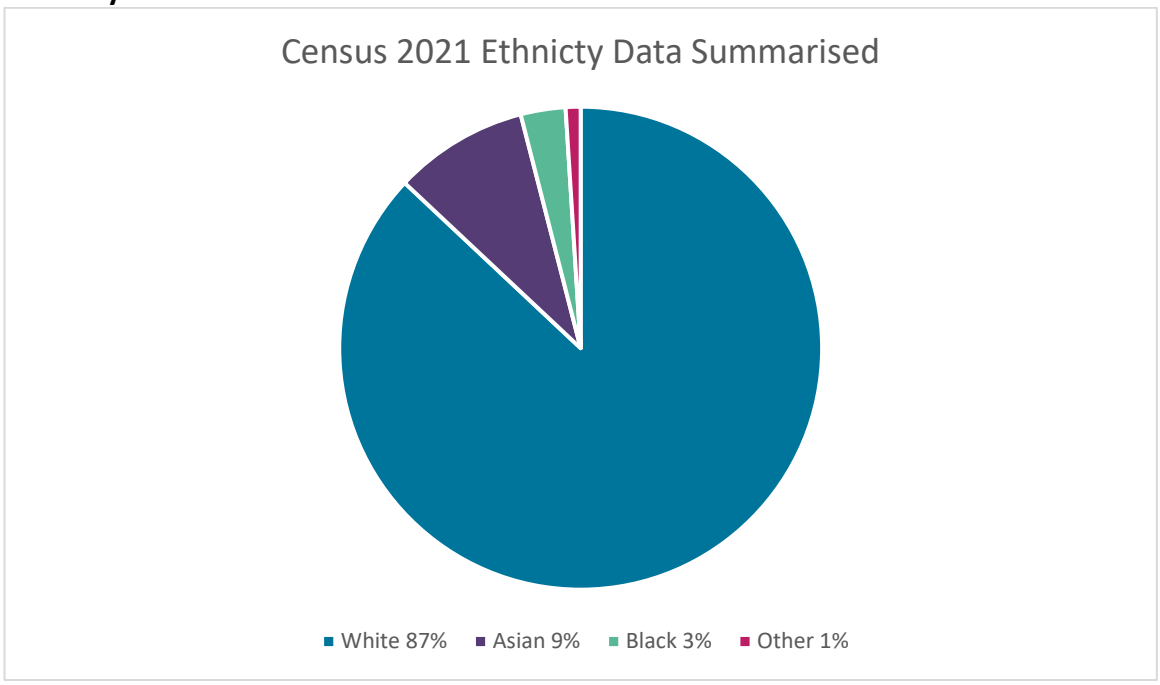
This EDI data is further broken down below into Registrant Members and Lay/Chairs (who cannot be Registrants). The breakdown of Registrant Members is then compared to combined data from the two professional registers. Lay/Chair data is compared to the most recent CENSUS data from 2021.

General Pharmaceutical Council

Further Analysis of EDI Data according to Ethnicity

Comparing Lay/Chair Member Data with 2021 Census (Expressed as Percentages)

Ethnicity Data from CENSUS 2021



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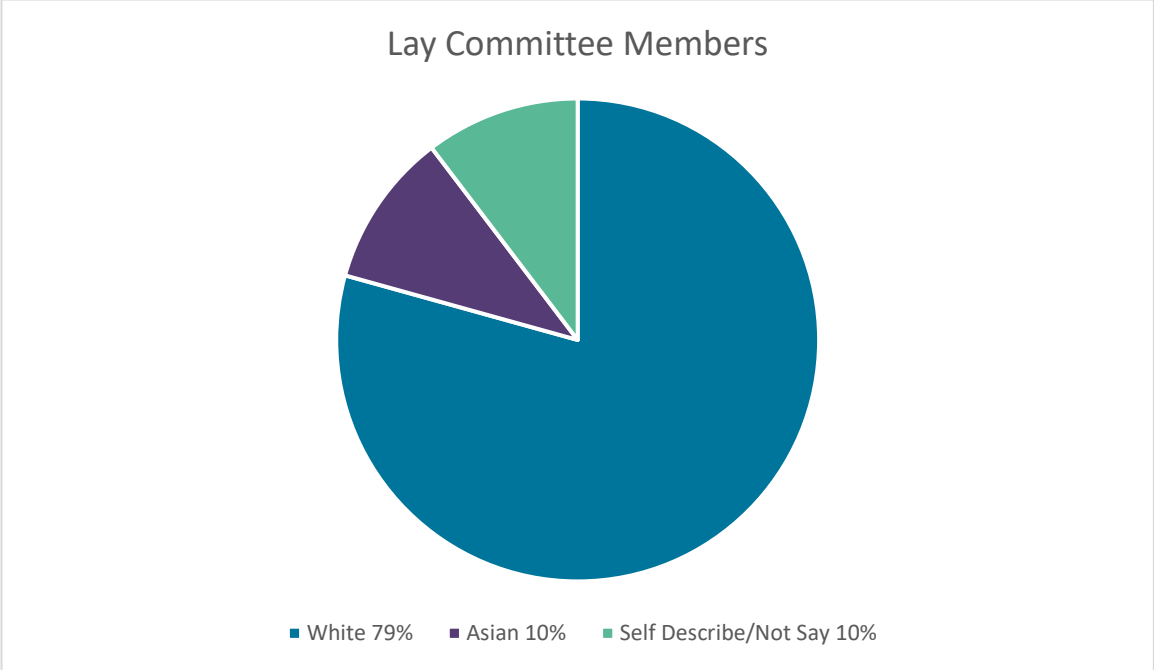
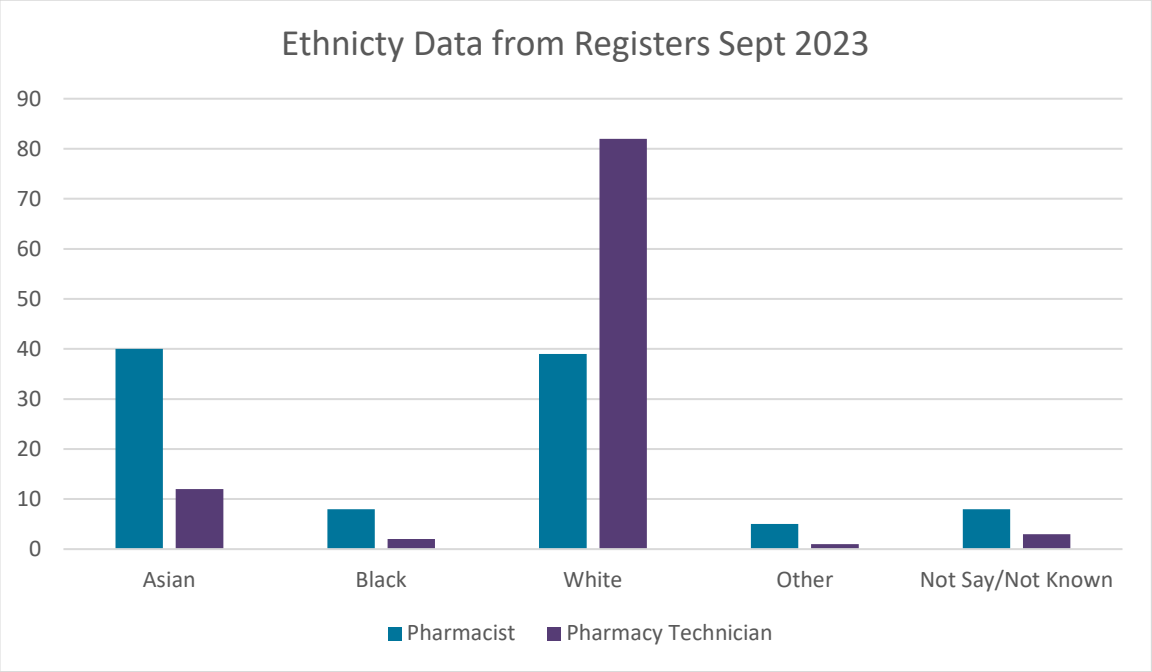
Ethnicity Data Lay Committee Members



Comparing Registrant Statutory Committee Member Data with Registrant Data from both the Pharmacy Technician and Pharmacist GPhC Registers (Expressed as a Percentage):

Ethnicity Data from the Registers of Pharmacists and Pharmacy Technicians

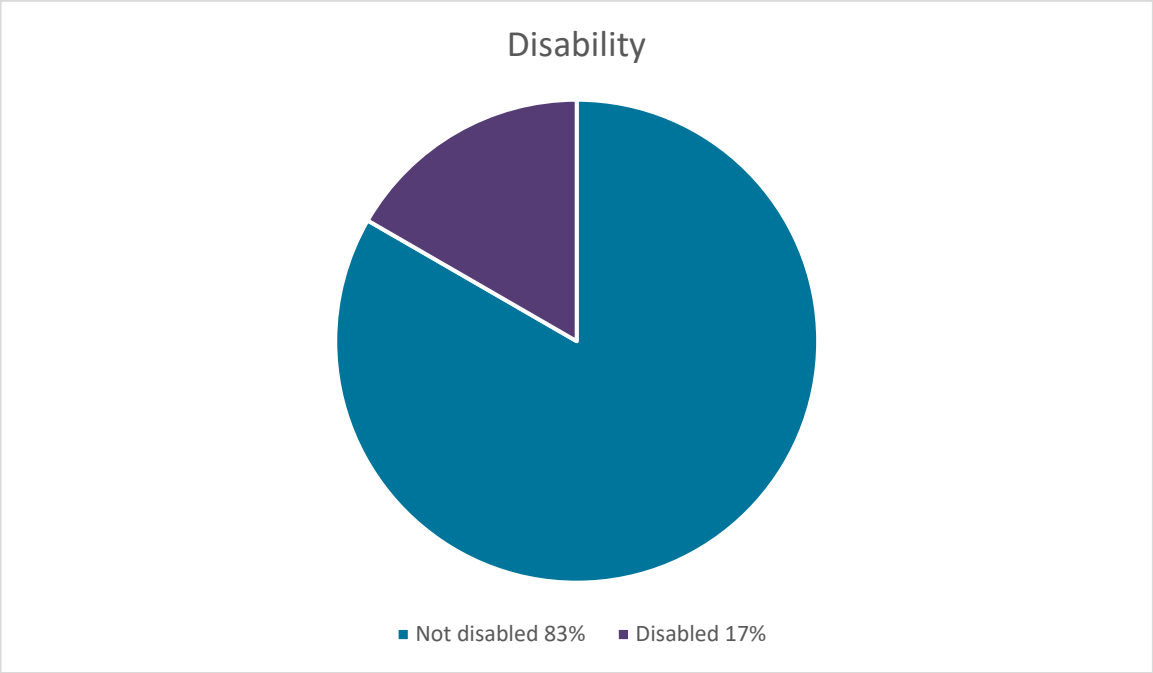


General Pharmaceutical Council

Ethnicity Data Registrant Members

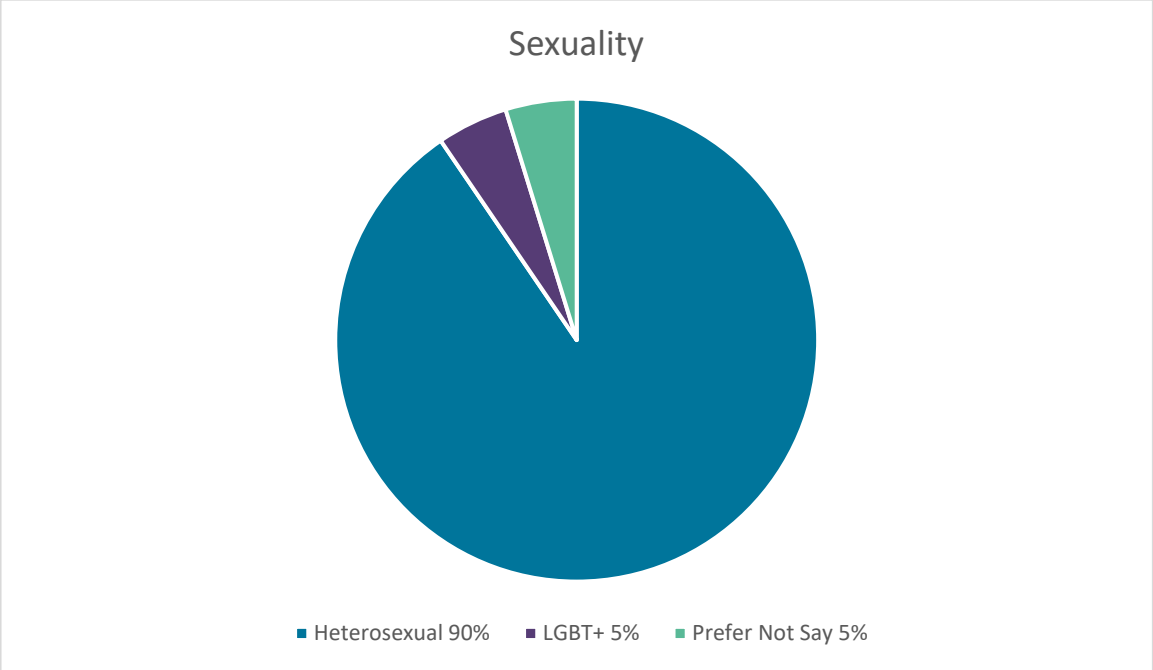
Further Analysis of EDI Data according to Disability

The 2021 CENSUS found that around 18% of people are now living with a long-term physical or mental health condition. The data on disability for Committee Members is set out below.



Further Analysis of EDI Data according to Sexuality

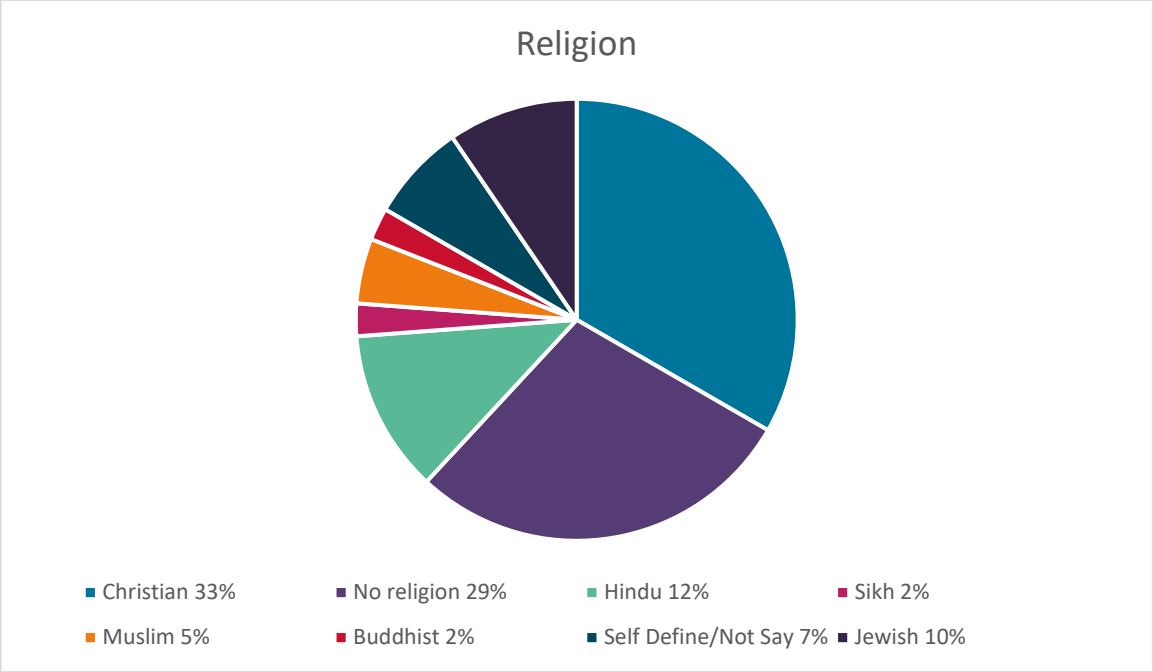
The 2021 CENSUS found that around 89% of people describe themselves as heterosexual, 3% as LGBT+ and 8% would not say. The data on sexuality for Committee Members is set out below.



Further Analysis of EDI Data according to Religion

The 2021 CENSUS found the following percentages in respect of responses to the question of religion: Christian – 46%, No religion 37%, Muslim – 7%, Hindu – 2%.

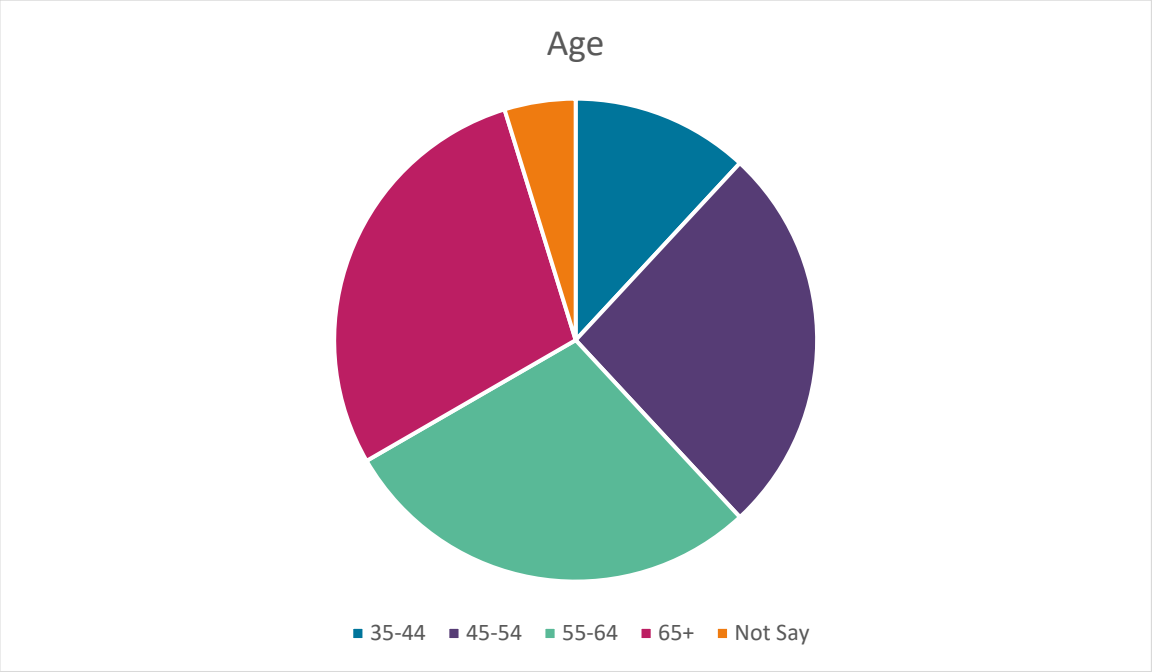
The religious breakdown of Committee Members is set out below.



Further Analysis of EDI Data according to Age Groupings

The 2021 CENSUS breaks down into the following percentages according to age (percentages for those under the age 18 are not included) 18-34 – 22%, 35-44 – 13%, 45-54 – 13%, 55-64 – 13%, over 65 – 19%.

The age breakdown of Committee Members.



General Pharmaceutical Council

Routine policy updates: conflicts of interest, gifts and hospitality

Meeting paper for Council on 07 December 2023

Not confidential

Purpose

To present minor updates to our 'Conflicts of Interest' and 'Gifts and Hospitality' policies, as part of a scheduled review.

Recommendations

The Council is asked to approve the updated policies, as recommended by the Workforce Committee.

1. Introduction

1.1 As part of good governance, our policies and procedures are reviewed on a regular basis to ensure that they remain fit for purpose and in line with relevant legislation and other good practice. We have a process for tracking and monitoring corporate policies, which includes agreed review cycles for each individual policy or procedure.

1.2 This paper proposes minor updates to our Conflicts of Interest policy (GPhC0038) and Gifts and Hospitality policy (GPhC0039). Any amendments to these policies need to be approved by Council, as they apply to all Council members. The Conflicts of Interest policy is attached at **Appendix 1** and the Gifts and Hospitality policy at **Appendix 2**.

1.3 The proposed amendments were presented to the Workforce Committee on 20 October 2023 and subsequently recommended to Council for approval.

2. Key considerations

2.1 Following our review, we are satisfied that these policies remain fit for purpose, in line with good practice and do not require any major updates:

- The 'Conflicts of Interest' policy was updated significantly in 2019, which included the development of new principles for identifying, managing and recording conflicts of interest at the time. This policy continues to effectively support our processes for managing and recording conflicts, and it does not require any substantial updates at this time. Some minor updates have been made to reflect staff working arrangements.

- Similarly, the 'Gifts and Hospitality' policy was also updated significantly in 2019 and does not require any significant changes at this time. The threshold for declaring gifts and hospitality remains at £20.00 – this sits in the middle of the thresholds used by other regulators across healthcare and beyond, where the thresholds range from £10 - £30. We have also added a new table at paragraph 5.7, to show how the threshold works in practice and to support understanding.

3. Equality and diversity implications

3.1 This paper does not raise any specific equality or diversity issues. The policies set out the expectations placed on all staff and Council members, to support a consistent approach.

4. Communications

4.1 If approved, we will publish the updated policies on our intranet and raise awareness with staff through additional communications. These policies are also published on our external website for full transparency.

5. Resource implications

5.1 This paper does not raise any specific resource considerations. The Executive Office and Governance Team continue to manage the conflicts, gifts and hospitality process, which includes maintaining the register, publishing declarations on the external website and giving advice to Council members and staff on any queries.

6. Risk implications

6.1 Integrity is a principle of public life and, as a regulator, impartiality and independence are vital to our effectiveness and the public interest. We must be objective in our decision-making, and personal interests should never influence our decisions at work.

6.2 The proper identification and management of potential or actual conflicts of interest (which includes gifts and hospitality) is an essential component of good governance. All of us must ensure that we are able to recognise any potential conflict of interests we have and that they do not affect, or appear to affect, any of our decisions.

6.3 Our process for managing conflicts of interest is also considered by our external auditors each year as part of our annual reporting process and no issues have been raised. The approach has also been considered by the PSA in the past, as part of its assessment of the General Standards and again no issues have been raised.

7. Recommendations

The Council is asked to approve the updated policies, as recommended by the Workforce Committee.

Laura McClintock, Chief of Staff
General Pharmaceutical Council

8 November 2023

General Pharmaceutical Council

Conflicts of interest policy

GPHC0038 Version 1.3

This policy sets out how we identify, manage and record conflicts of interest and outlines the key responsibilities of Council members and staff.

Policy details

Policy reference	GPHC0038
Version	1.3
Policy author	Laura McClintock, Chief of Staff
Approved for issue by	Council, 09 November 2023
Effective from	09 November 2023
Next review	10 November 2025

Version control tracker

Version	Approved date	Description of change	Amendments by
1.2	06.12.2019 – by Council	Updated format and content, including adding new guiding principles for managing conflicts and providing more information and examples about what constitutes a conflict of interest. Also, cross-referenced a number of other related policies, as well as GDPR requirements.	Laura McClintock, Chief of Staff
1.3	09/11/2023 – to be approved by Council	Updated as part of a scheduled review. Minor updates to staff details and inclusion of the Multiple Employment Policy.	Laura McClintock, Chief of Staff

Contents

1. Introduction

1.1. Integrity is a principle of public life and, as a regulator and public authority, impartiality and independence are vital to our effectiveness and the public interest. We must be objective in our decision-making, and personal interests should never influence our decisions at work.

1.2. We recognise that the identification and management of potential or actual conflicts of interest is an essential component of good governance. All of us must ensure that we are able to recognise any potential conflict of interests we have and that they do not affect, or appear to affect, any of our decisions.

1.3. In line with our **'Values, conduct and behaviours for Council members, associates and partners'** policy, these groups are required to disclose any commitment or activity which may be perceived as a potential conflict of interest in respect of the role they undertake with the GPhC, and to comply with all applicable GPhC standards and policies, including those relating to conflicts of interests and gifts and hospitality.

1.4. Similarly, our **'Code of Conduct '** for GPhC staff states that all employees must declare if they or their relatives, friends or associates have any interests, financial or otherwise that could influence, or be seen to influence, decisions that they may take on behalf of the GPhC.

1.5. All Council members and staff are required to declare and register relevant interests, when appropriate and in line with this policy.

2. Purpose

2.1. This policy provides advice on how we identify, manage and record conflicts of interest, or potential conflicts of interest. It helps to protect the integrity of our Council members, staff and our organisation, and sets out guidance that must be followed to ensure that a conflict of interest, or potential conflict of interest, does not have an adverse effect on our work or on public confidence in the GPhC.

2.2. It also provides guidance on what types of interests should be declared by Council members and staff relating to them, their family members or their close acquaintances that could influence, or be seen to influence, their objectivity when making decisions on behalf of the GPhC, or in connection with the GPhC. These groups must also declare any paid employment or relevant voluntary activity.

3. Scope

3.1. This policy applies to Council members and staff. There are some additional requirements for the Executive outlined below.

3.2. As well as Council members, there are a number of groups who help the GPhC to fulfil its regulatory functions. We use the broad terms 'associate' and 'partner' to describe these groups. Associates and partners fill a variety of roles, providing a wide range of knowledge and skills to support the GPhC's work.

3.3. Associates and partners are covered by separate policies. This is because these groups may also need to comply with legislative and other requirements relevant to their specific functions. For example, there are specific legislative provisions relating to conflicts of interest for statutory committee members in the General Pharmaceutical Council (Statutory Committees and their Advisers Rules) Order of Council 2010.

3.4. If you are not sure whether this policy applies to you, please contact the Executive Office and Governance Team for information and advice. You should always err on the side of caution and declare any interests if you are unsure of their relevance.

4. Conflicts of Interest

Guiding Principles

4.1. When identifying, managing and recording conflicts of interest, you should be guided by the following principles:

- Always act with honesty and integrity
- Be open about the relationships and personal interests that could influence, or be seen to influence your independent judgement
- Make full, accurate and timely declarations (declarations should be made on appointment, as and when they arise throughout the year, as well as during the bi-annual attestation process for Council members and senior staff)
- Always alert the relevant person to any actual or potential conflict of interests and agree with them how this should be managed
- Notify the relevant person immediately if your circumstances change, in case this gives rise to conflict of interests
- Do not seek to make a profit or benefit for yourself or others by making personal use of information acquired during your duties
- Ensure you do not leave yourself open to improper influence or the perception of improper influence through the acceptance of gifts and hospitality, or otherwise.
- Read, understand and comply with this policy and ask questions if you need clarification or advice
- Speak up if you have concerns, including about any breach, or potential breach of this policy.

What constitutes a 'conflict of interest'

4.2. A conflict of interests arises when your responsibilities could be affected by your personal or professional situation, financial matters or a close personal relationship. It could also arise if your responsibilities could be affected by a personal interest of your close family or any other close personal relationship with an individual. It becomes significant if any person, internally or externally, might reasonably believe there is a risk of your actions, or those of a personal acquaintance, being inappropriately influenced.

4.3. You should declare any interests, financial or otherwise, that you, your family or friends have that could influence, or be seen to influence, decisions that you may take on behalf of the GPhC. This

includes any activity for which you are paid if this could influence, or be seen to influence, decisions that you may take on behalf of the GPhC.

4.4. A conflict of interest may also be anticipatory, where the actions of an individual may be perceived to put them or their family or close associates in a more favourable position.

4.5. Conflict of interests, or perceived conflict of interest, may arise in various ways, such as:

Financial interests – direct
This should include but is not restricted to:

- Any activity for which you are paid, whether or not the activity relates to matters concerning the GPhC, such as:
  - full time or part-time employment of any kind, including paid directorships
  - paid offices held
  - self-employment, such as freelance, contract or consultancy work
  - sponsorship, awards, bursaries, research grants etc.
- Ownership of any company, business or consultancy
- Direct beneficial interests or shareholdings in companies or other bodies that could be perceived as relevant to the GPhC (on your own behalf or on behalf of a spouse, partner, child or children)
- Any business dealings or other financial transactions, including any contract to supply goods or services to the GPhC, or to any person or organisation connected to the activities of the GPhC.

Financial interests – indirect and relating closely to GPhC activity
You should declare all indirect financial interests arising from connections with bodies which have a direct financial interest in matters concerning the GPhC or from being a business partner of, or being employed by, a person with such an interest.

Non-financial interests
You should declare all non-financial interests that relate to unpaid office in, membership of or involvement in organisations, associations or other bodies which are regulated in any way by the GPhC or whose activities could be perceived as relevant to the GPhC.

For example, any office held in any healthcare related organisation in the public, private or third sector. This includes NHS authorities, trusts or health boards, regulatory bodies, professional associations, trade unions and charities, trusts and voluntary organisations. This would also include membership of any organisation whose principal purposes include influencing public opinion or policy such as membership of ‘think tank’ or lobbying organisations.

Close family interests
You should declare all financial and non-financial interests of close family members and persons living in the same household (where these are known to you) that could be thought of as relevant to GPhC activity. Close family members include personal partners, parents, children (adult and minor), brothers, sisters and the personal partners of any of these.

4.6. This list is not exhaustive. If you are unsure of whether a conflict has risen or may arise in future, please seek advice from the Executive Office and Governance Team. If you are in any doubt as to whether or not something represents an interest, you should err on the side of caution and declare it.

5. Declaring and recording conflicts of interest

5.1. Council members and staff a responsibility to provide relevant information and make appropriate declarations in line with this policy. This includes providing updated information as soon as possible following a change in circumstances.

5.2. The GPhC is committed to transparency in its decision making. As such, the Council member and Executive register of interests is made public on the GPhC website.

5.3. Every six months (March and September) Council members and senior staff are asked to update their declaration of interests, including sending in a nil return, if appropriate.

5.4. In March and September, the finance team reconcile the Council member and senior staff declarations against the prior six months' purchases to check if there have been any related party transactions. This is then reported to the external auditors as part of the year end processes.

5.5. The information provided through declarations will be processed in accordance with data protection principles as set out in the UK GDPR and the Data Protection Act 2018. Data will be processed only to ensure the objectivity and transparency of GPhC decision making.

5.6. The Standing Orders of Council provide further guidance on how conflicts should be declared and managed at Council meetings. This includes how conflicts are recorded in the minutes.

6. Gifts and hospitality

6.1. Council members and staff must not accept gifts or hospitality that might reasonably be seen to compromise or call into question their independence, impartiality or personal judgement, or that of the GPhC. This includes anything that could place these groups under an obligation to outside individuals or organisations that might influence their performance of official duties or, just as importantly, that might give rise to a perception that they might be so influenced.

6.2. Further guidance can be found in the Gifts and Hospitality policy.

7. Supporting documents

7.1. This policy is supported by a range of other supporting policies and procedures, which can be found on the Governance, HR and Finance pages of the intranet, and in the policies and procedures library. This includes:

- Standing Orders of Council
- Gifts and hospitality policy

- Multiple Employment Policy
- GPhC Staff Code of Conduct
- Values, conduct and behaviours for Council members, associates and partners
- Fraud and Anti-bribery policy
- Disciplinary policy and procedures
- Raising concerns policy

7.2. For more information or advice about this policy, please contact the Executive Office and Governance Team.

General Pharmaceutical Council

Gifts and hospitality policy

GPHC0039 Version 1.3

This policy sets out guidance on what to do if you are offered gifts and/or hospitality in connection with GPhC activities.

Policy details

Policy reference	GPHC0039
Version	1.3
Policy author	Laura McClintock, Chief of Staff
Approved for issue by	Council, November
Effective from	09 November 2023
Next review	10 November 2025

Version control tracker

Version	Approved date	Description of change	Amendments by
1.2	05/12/2019 – by Council	Updated format and content of the previous policy, including adding new guiding principles to align with the updated declarations of interest policy	Laura McClintock, Chief of Staff
1.3	09/11/2023 – to be approved by Council	Updated as part of a scheduled review. No change to the threshold for declarable gifts/hospitality, as the limit remains in line with good practice. Additional table added at paragraph 5.7, to show how the threshold works in practice and to support understanding. Added reference to Multiple Employment Policy.	Laura McClintock, Chief of Staff

Contents

1. Introduction

1.1. Integrity is a principle of public life and, as a regulator, impartiality and independence are vital to our effectiveness and the public interest. We must be objective in our decision-making, and personal interests should never influence our decisions at work.

1.2. We recognise that the identification and management of potential or actual conflicts of interest (which includes gifts and hospitality) is an essential component of good governance. All of us must ensure that we are able to recognise any potential conflict of interests we have and that they do not affect, or appear to affect, any of our decisions.

1.3. In line with our **'Values, conduct and behaviours for Council members, associates and partners'** policy, these groups are required to disclose any commitment or activity which may be perceived as a potential conflict of interest in respect of the role they undertake with the GPhC, and to comply with all applicable GPhC standards and policies, including those relating to gifts and hospitality.

1.4. Similarly, our **'Code of Conduct'** for GPhC staff specifies that certain gifts may be accepted provided this is compliant with the principles of the GPhC's formal arrangements as set out in our anti-bribery policy, declarations of interest policy, and this gifts and hospitality policy.

2. Purpose

2.1. As a regulator, we need to observe high standards of ethical behaviour. We recognise that it is important to build and maintain effective networks to support our work. This can occasionally give rise to offers of gifts and/or hospitality.

2.2. This policy provides guidance on what to do if you are offered gifts and/or hospitality in connection with GPhC activities.

2.3. It also helps to protect the integrity of our workforce and our organisation and sets out guidance that must be followed to ensure that the acceptance of gifts or hospitality does not have an adverse effect on our work or on public confidence in the GPhC.

3. Scope

3.1. This policy applies to Council members and staff. There are some additional requirements for the Executive outlined below.

3.2. As well as Council members, there are a number of groups who help the GPhC to fulfil its regulatory functions. We use the broad terms 'associate' and 'partner' to describe these groups. Associates and partners fill a variety of roles, providing a wide range of knowledge and skills to support the GPhC's work. Associates and partners are covered by separate policies. This is because these groups may also need to comply with legislative and other requirements relevant to their specific functions.

3.3. If you are not sure whether this policy applies to you, please contact the Executive Office and Governance Team for information and advice. You should always err on the side of caution and declare any interests if you are unsure of their relevance.

4. Guiding Principles

4.1. When identifying, managing and recording conflicts of interest (including gifts and hospitality), you should be guided by the following principles:

- Always act with honesty and integrity
- Be open about the relationships and personal interests that could influence, or be seen to influence your independent judgement
- Make full, accurate and timely declarations (declarations of interest should be made on appointment, as and when they arise throughout the year, as well as during the bi-annual attestation process for Council members and senior staff)
- Always alert the relevant person to any actual or potential conflict of interests and agree with them how this should be managed.
- Notify the relevant person immediately if your circumstances change, in case this gives rise to conflict of interests
- Do not seek to make a profit or benefit for yourself or others by making personal use of information acquired during your duties
- Ensure you do not leave yourself open to improper influence or the perception of improper influence through the acceptance of gifts and hospitality, or otherwise.
- Read, understand and comply with this policy and ask questions if you need clarification or advice
- Speak up if you have concerns, including about any breach, or potential breach of this policy

5. Guidance on gifts and hospitality

5.1. Generally, gifts should be avoided, where possible, and in all cases be considered carefully before being accepted.

5.2. Council members and staff **must not** accept any gifts or hospitality that might influence or compromise (or be seen to influence or compromise) their independence, impartiality or personal judgement, or that of the GPhC. This includes anything that could place these groups under an obligation to outside individuals or organisations that might influence their performance of official duties or, just as importantly, that might give rise to a perception that they might be so influenced.

5.3. There will often be an element of judgement in coming to a decision. When following this policy, common sense needs to apply about whether gifts or hospitality should be accepted. If acceptance of gifts and hospitality were challenged, it would be necessary to show that acceptance was lawful, appropriate and consistent with our rules and that personal judgement or integrity had not been compromised.

5.4. For example, you should never accept any gift and/or hospitality from any person or organisation against which you know we are engaged in or considering formal regulatory action, or from any person or organisation with which you know we are considering entering into a contract.

5.5. Declining gifts and hospitality can sometimes seem discourteous; however, this may be necessary to uphold high standards of propriety and guard against any concern about a perceived or actual conflict of interest, or creation of an undue obligation.

5.6. It is not necessary to declare/record gifts with a value of less than £20, or hospitality such as a light lunch as part of a working event. If there is any doubt about the intentions or the circumstances, then the gift or hospitality should be declined.

5.7. The following table should be used to help you to understand what to declare, accept or decline:

Value of gift / hospitality	Declare	Decline
Token value (e.g. pens, diaries etc)	No	No
Less than £20	No	No – however, if there is any doubt about the intentions or the circumstances, then the gift or hospitality should be declined.
More than £20	Yes	**Gifts:** Generally, gifts over this value should not be accepted. In some circumstances, it may be difficult to refuse a higher value gift (for example, when it is offered by an international delegation). In these cases, the gift may for example be held by the GPhC as a whole rather than at individual level. **Hospitality:** Some types of hospitality over the value of £20 may be appropriate and proportionate – for example, a working lunch, dinner, evening reception or other event. If in doubt, Council members and staff should seek guidance from the Executive Office and Governance team on gifts and hospitality over the value of £20.

5.8. Declarations are made by the informing the Executive Office, who will then update the relevant Register.

5.9. Additionally, every six months (usually March and September) Council members, and the Executive will be asked to update their declaration of gifts and hospitality, including sending in a nil return, if appropriate. These are published on the GPhC website and recorded by the Executive Office and Governance team.

5.10. If you are aware of such an offer in advance (this is more commonly the case with hospitality than with a gift) you should seek advice from the Executive Office and Governance Team.

6. Offering gifts and hospitality

6.1. Any offering, or giving, of gifts and/or hospitality must:

- be given at a corporate level, not an individual level;
- be appropriate, reasonable, proportionate, given in good faith and at an appropriate time; and be given openly;
- not be given or received with the intention of influencing a third party to obtain or retain business or business advantage, to reward the provision or retention of business or business advantage, or in an explicit or implicit exchange for favours or benefits;
- not constitute an offence under the Bribery Act 2010 (**see GPhC Fraud and Anti-bribery policy** for more information);
- not include cash or a cash equivalent;

6.2. The purchase of gifts, using GPhC funds, should only be considered in exceptional circumstances. It may be appropriate for the GPhC to provide hospitality, for example, a light lunch as part of a stakeholder event or meeting.

6.3. In both scenarios, you must seek approval from the relevant budget holder (Head of Function or above), or advice from the Executive Office and Governance Team before proceeding.

7. Supporting Documents

7.1. This policy is supported by a range of other supporting policies and procedures, which can be found on the Governance, HR and Finance pages of the intranet, and in the policies and procedures library. This includes:

- Standing Orders of Council
- Conflicts of Interest Policy
- Multiple Employment Policy
- GPhC Staff Code of Conduct
- Values, conduct and behaviours for Council members, associates and partners
- Fraud and anti-bribery policy
- Disciplinary policy and procedures
- Raising concerns policy

7.2. For more information or advice about this policy, please contact the Executive Office and Governance Team.

General Pharmaceutical Council

Minutes of the Audit and Risk Committee meeting held on 21 September 2023

Minutes of the public items

Present:

Neil Buckley (Chair)

Helen Dearden

Ann Jacklin

Elizabeth Mailey

Jayne Salt

Apologies:

None

In attendance:

Duncan Rudkin	Chief Executive and Registrar
Hannah Fellows	Interim Director – Fitness to Practise
Laura McClintock	Chief of Staff and Associate Director – Corporate Affairs
Gary Sharp	Associate Director – HR and Organisational Development
Rob Jones	Head of Risk Management and Audit
Janet Collins	Senior Governance Manager
Kelly Reid	TIAA
Richard Weaver	Haysmacintyre
David Hajduk	Associate Director – Technology
Gary Hamilton	Applications Business Partner
Glenn Mathieson	Head of Initial Assessment (Fitness to Practise)

1. Attendance and introductory remarks

1.1 The Chair welcomed those present to the meeting, including Elizabeth Mailey who had recently joined the committee and was attending her first meeting. He thanked Aamer Safdar and Yousaf Ahmad, who had recently left the Committee, for their contributions to its work during their membership.

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. Item 3 - Minutes of previous meeting – 25 May 2023 (23.09.ARC.01)

3.1 **The minutes of the public items considered at the meeting on 25 May 2023 were approved.**

4. Item 5 - Actions and matters arising – public items

4.1 The committee noted the action log. An update on the purchase order system had been sent to the members with the papers.

5. Item 8 – Risk Management policy (including risk appetite statement)

5.1 Rob Jones introduced the updated Risk Management policy and risk appetite statement.

5.2 There had been four key changes to the policy since the Council had last approved it in May 2022:

- The risk appetite statement had been updated following sessions with the Council and now included a stronger section on EDI which specifically referenced the organisation's positive action approach, as well as more explicit reference to acting on changes in the external environment which could impact patient safety;
- A revised risk matrix (already seen by SLG, the Committee and the Council);
- A new set of risk signficance indicators; and
- A more detailed section on referrals to the Information Commissioner's Office (ICO).

5.3 The cover paper suggested that the review period – currently 12 months – could be extended to two years, with the next review being a substantive review and re-draft.

5.4 **The Committee agreed with the revised review period and recommended the updated Risk Management policy and risk appetite statement to Council for approval.**

6. Item 10 – Internal audit (23.09.ARC.07 a-c)

6.1 Kelly Reid of TIAA presented the following:

Summary internal controls assurance report (SICA)

6.2 The ICO Accountability Framework Self-Assessment (part 2) had been completed as scheduled. The audit of budgetary controls had been re-scheduled to December by agreement with the GPhC and TIAA due to better accommodate the availability of resources in both organisations.

6.3 Having discussed the SICA, the Committee agreed that the GPhC's whistleblowing policy and processes should be added to the audit plan for 2024.

Internal audit recommendations tracker

6.4 The Committee noted the recommendations tracker

ICO Accountability Framework self-assessment – part 2

6.5 The accountability self-assessment was designed to help organisations assess the extent to which they were meeting the ICO's expectations in ten areas. The TIAA review had been carried out to discuss and assess policies, procedures and other measures that were in place at the GPhC. Unlike other audits, it did not give a view on the assurance level.

6.6 TIAA had made 14 recommendations, not all of which had been accepted or partially accepted. However, TIAA was content with this as the framework was somewhat generic and the GPhC management response had given good, considered reasons for these decisions and that the response was proportionate.

6.7 The Committee agreed that some push-back to audit recommendations was healthy as it showed that the findings had been properly thought through.

7. Item 11 -Never events and serious incident review (23.09.ARC.08)

7.1 David Hajduk, Gary Hamilton and Glenn Mathieson joined the meeting for this item.

7.2 On 28 July it was found that 73 concerns submitted through the GPhC website had not been automatically pushed through to the CRM system, following the deployment of new code designed to implement a business change. The issue had first occurred on 26 May. None of the concerns were subsequently identified as serious, so there had been no impact on patient safety.

7.3 While new code would usually be fully tested, the developer had taken the decision not to do so on this occasion, partly due to a lack of available test environments. Following the incident, testing decisions were now checked with the Applications Business Partner.

7.4 The Committee discussed the manual checks suggested in recommendation 5 of the report. These were currently taking place daily and the SLG had requested that they should continue while work was carried out to establish which critical workflows would need immediate action if found not to be working and a procedure was established to support this. The Committee was keen that additional burdens should not be placed on staff once assurance had been achieved.

7.5 The Committee noted that action had been taken swiftly once the issue was identified, that open discussions had taken place and the various parties kept informed, all of which pointed to a positive culture.

8. Item 12 – Fraud and Anti-bribery policy (23.09.ARC.09)

8.1 RJ introduced the new Fraud and Anti-bribery policy. An anti-bribery policy was already in place, but the fraud element was new. Mandatory training had been provided for staff and almost all had completed it in the required time, with HR following up with the small number who had not.

8.2 The process for dealing with possible fraud, as set out in the policy, was not overly prescriptive as it was recognised that it needed to be flexible to allow for varying circumstances.

8.3 It was agreed that a third level of reporting should be added in the Responsibilities section, in the event that it was not appropriate for concerns to be reported to the Director of Adjudication and Financial Services.

8.4 The Committee discussed the links between the new policy and those relating to declarations of interest, gifts and hospitality, multiple employment and raising concerns. The Chair asked for the list of current policies to be re-circulated to the Committee.

8.5 **The Committee approved the Fraud and Anti-bribery policy.**

9. Item 14 - Target operating model and system prioritisation (23.09.ARC.11)

9.1 DR introduced this item. Work was taking place to design and implement a target operating model for the GPhC with greater emphasis on the customer journey of registrants, patients and the public, joining up activities across functions and informing staff resourcing as a whole organisation.

9.2 The work included moving away from excessive reliance on manual processes but it was important to design the operating model first so that resources were not spent on automating processes which could either be stopped or done in a better way.

9.3 There were a number of external groups which could provide input on the customer journey. The programme was ambitious but was being led by the Head of Renewal Programme who already had significant experience of the GPhC's systems and processes.

9.4 The Chair of the Committee would havea discussion with the Head of Renewal Programme (who was not able to be at the meeting) about how the work would be carried out.

10. Item 19 – Any other business

10.1 There was no other business.

Date of next meeting: Tuesday 5 December 2023