professional standards authority

Annual review of performance 2015/16

General Pharmaceutical Council

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care[1] promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.[2] We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

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1 The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

2 *Right-touch regulation revised (October 2015)*. Available at http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

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About the General Pharmaceutical Council

The General Pharmaceutical Council (the GPhC) regulates the practice of pharmacists and pharmacy technicians in Great Britain. Its work includes:[3]

- Setting standards for education and training of pharmacists and pharmacy technicians, accrediting education and training providers, approving qualifications and assuring the quality of education and training
- Setting and maintaining standards of conduct, ethics and proficiency for pharmacists and pharmacy technicians
- Maintaining a register of pharmacists and pharmacy technicians ('registrants') that meet those standards
- Setting standards of continuing professional development to ensure that registrants maintain their ability to practise safely and effectively
- Maintaining a register of practitioners and pharmacy premises that meet those standards
- Taking action to restrict or remove from practice individual registrants who are not considered fit to practise.

As at 1 June 2016, the GPhC register comprised:

- 51,980 pharmacists
- 23,121 pharmacy technicians.

The annual registration fee is:

- £250 for pharmacists
- £118 for pharmacy technicians.

[3] The GPhC also regulates pharmacy premises (see paragraph 2.6).

At a glance

Annual review of performance

Regulator reviewed: **General Pharmaceutical Council**

Standards of good regulation

Core functions	Met
Guidance and Standards	4/4
Education and Training	4/4
Registration	6/6
Fitness to Practise	10/10

1. The annual performance review

1.1 We oversee the nine health and care professional regulatory organisations in the UK, including the GPhC.[4] More information about the range of activities we undertake as part of this oversight, as well as more information about these regulators, can be found on our website.

1.2 An important part of our oversight of the regulators is our annual performance review, in which we report on the delivery of their key statutory functions. These reviews are part of our legal responsibility. We review each regulator on a rolling 12-month basis and vary the scope of our review depending on how well we see the regulator is performing. We report the outcome of reviews annually to the UK Parliament and the governments in Scotland, Wales and Northern Ireland.

1.3 These performance reviews are our check on how well the regulators have met our *Standards of Good Regulation* (the Standards) so that they protect the public and promote confidence in health and care professionals and themselves. Our performance review is important because:

- It tells everyone how well the regulators are doing
- It helps the regulators improve, as we identify strengths and weaknesses and recommend possible changes.

The Standards of Good Regulation

1.4 We assess the regulators' performance against the Standards. They cover the regulators' four core functions:

- Setting and promoting guidance and standards for the profession (Guidance and Standards)
- Setting standards for and quality assuring the provision of education and training (Education and Training)
- Maintaining a register of professionals (Registration)
- Taking action where a professional's fitness to practise may be impaired (Fitness to Practise).

1.5 The Standards describe the outcomes we expect regulators to achieve in each of the four functions. Over 12 months, we gather evidence for each regulator to help us see if they have been met.

1.6 We gather this evidence from the regulator, from other interested parties, and from the information that we collect about them in other work we do. Once a year, we collate all of this information and analyse it to make a recommendation to our internal panel of decision-makers about how we

[4] These are the General Chiropractic Council; the General Dental Council; the General Medical Council; the General Optical Council; the General Osteopathic Council; the General Pharmaceutical Council; the Health and Care Professions Council; the Nursing and Midwifery Council; and the Pharmaceutical Society of Northern Ireland.

believe the regulator has performed against the Standards in the previous year. We use this to decide what type of performance review we carry out.

1.7 We will recommend that an additional review of their performance is unnecessary if:

- We identify no significant changes to the regulator's practices, processes or policies during the performance review period; and
- None of the information available to us indicates any concerns about the regulator's performance that we wish to explore in more detail.

1.8 We will recommend that we ask the regulator for more information if:

- There have been one or more significant changes to a regulator's practices, processes or policies during the performance review period; but
- None of the information we have indicates any concerns or raises any queries about the regulator's performance that we wish to explore in more detail;
- This will allow us to assess the reasons for the change(s) and the expected or actual impact of the change(s) before we finalise our performance review report. If the further information provided by the regulator raises concerns, we reserve the right to make a further recommendation to the panel that a 'targeted' or 'detailed' review is necessary.

1.9 We recommend a 'targeted' or 'detailed' performance review if we consider that there are one or more aspects of a regulator's performance we wish to examine in more detail because the information we have (or the absence of relevant information) raises one or more concerns about the regulator's performance against one or more of the Standards:

- A 'targeted' review may be carried out when we consider that the information we have indicates a concern about the regulator's performance in relation to a small number of specific Standards, usually all falling within the same performance review area
- A 'detailed' review may be carried out when we consider that the information we have indicates a concern about the regulator's performance across several Standards, particularly where they span more than one area.

1.10 We have written a guide to our performance review process, which can be found on our website www.professionalstandards.org.uk

2. What we found – our decision

2.1 We carried out an initial assessment of the GPhC's performance for the year beginning 1 April 2015. Our review included an analysis of the following:

- GPhC Council agenda, papers and minutes including performance, policy and committee reports
- Policy and guidance documents
- Statistical performance dataset (see sections below)
- Third party feedback
- A check of the GPhC register
- Information available to us though our review of final fitness to practise decisions under the Section 29 process.[5]

2.2 As a result of this assessment, we recommended a targeted review to look at the GPhC's performance against Standard 6 for Fitness to Practise. This recommendation was accepted. The panel also identified a further issue relating to Standard 5 for Fitness to Practise and decided that a targeted review was required.

2.3 The GPhC provided us with more information in relation to these Standards. After, careful consideration of this extra information, we recommended that the GPhC had met all of the Standards in 2015/16. The reasons for this recommendation are set out in the following sections of the report.

Summary of the GPhC's performance

2.4 For 2015/16 we have concluded that the GPhC:

- Met all of the *Standards of Good Regulation* for Guidance and Standards
- Met all of the *Standards of Good Regulation* for Education and Training
- Met all of the *Standards of Good Regulation* for Registration
- Met all of the *Standards of Good Regulation* for Fitness to Practise.

2.5 This is the first year that the GPhC has met all of the Standards. In the past, we were particularly concerned about the GPhC's performance against Standard 6 for Fitness to Practise (which it has not previously met – other than in 2012/13). We welcome the GPhC's progress in this area and we are pleased that this Standard was met in 2015/16.

[5] Each regulator we oversee has a 'fitness to practise' process for handling complaints about health and care professionals. The most serious cases are referred to formal hearings in front of fitness to practise panels. We review every final decision made by the regulators' fitness to practise panels. If we consider that a decision is insufficient to protect the public properly we can refer them to Court to be considered by a judge. Our power to do this comes from Section 29 of the NHS Reform and Health Care Professions Act 2002 (as amended).

Pharmacy premises

2.6 The GPhC regulates premises as well as professionals by registering, setting standards for, and inspecting pharmacies.[6] In March 2016 Parliament approved changes to the GPhC's governing legislation[7] to allow it to take enforcement action where breaches of the *Standards for registered pharmacies* are found. At the time of writing a commencement date for the legislation has not yet been set. In the meantime the GPhC is developing proposals for how it will use these powers and will consult on them in due course.

2.7 This aspect of the GPhC's work is not properly captured by the *Standards of Good Regulation*. However, we recognise that the GPhC's work in this area significantly contributes to protecting the health, safety and wellbeing of members of the public, as the majority of interactions with pharmacy professionals occur in pharmacies. In 2016/17 we intend to review the *Standards of Good Regulation* and, as part of this work, we will consider how we can incorporate this important aspect of the GPhC's work in future performance reviews.

Key comparators

2.8 We have identified with all of the regulators the numerical data that they should collate, calculate and provide to us, and which items of data we think provide helpful context about each regulator's performance. Collection of this data should not be a burden on the regulators as it is necessary for their own management.

2.9 We expect to report on these comparators both in each regulator's performance review report and in our overarching reports on performance across the sector. We will compare the regulators' performance against these comparators where we consider it appropriate to do so.

2.10 The comparator data which the GPhC provided to us for the period 1 April 2015 to 31 March 2016 is:

[6] The Pharmaceutical Society of Northern Ireland (PSNI) is similar in that it registers and sets standards for pharmacy premises in Northern Ireland; however, the responsibility for inspection and enforcement lies with the Department of Health, Social Services and Public Safety Northern Ireland.
[7] The Pharmacy (Premises Standards, Information Obligations, etc.) Order 2016 made changes to the Pharmacy Order 2010

1	The number of registration appeals concluded, where no new information was presented, that were upheld	Q3 0	Q4 0
2	Median time (in working days) taken to process initial registration applications for	Q3[8]	Q4[8]
	• UK graduates	14 (9)	9 (6)
	• EU (non-UK) graduates	22 (2)	28 (4)
	• International (non-EU) graduates	17 (9)	39 (10)
3	Time from receipt of initial complaint to the final Investigating Committee/Case Examiner decision		
	• Median	48.8 weeks	
	• Longest case	197.1 weeks	
	• Shortest case	13.9 weeks	
4	Time from receipt of initial complaint to final fitness to practise hearing		
	• Median	96.6 weeks	
	• Longest case	263.6 weeks	
5	Time to an interim order decision from receipt of complaint	6 weeks	
6	Outcomes of the Authority's appeals against final fitness to practise decisions		
	• Dismissed	0	
	• Upheld and outcome substituted	0	
	• Upheld and case remitted to regulator for re-hearing	0	
	• Settled by consent	0	
	• Withdrawn	0	
7	Number of data breaches reported to the Information Commissioner	0	
8	Number of successful judicial review applications	0	

[8] The initial figure represents the median time between an initial registration application being received, and an entry being made on the GPhC register. The second figure (in brackets) is the median time between the completed application being approved for registration, and an entry being made on the register. The GPhC register is updated twice a month, on the 1st and 15th, and consequently, there can be a delay between an application being approved and the register being updated.

3. Guidance and Standards

3.1 The GPhC has met all of the *Standards of Good Regulation* for Guidance and Standards during 2015/16. Examples of how it has demonstrated this are set out below.

Standard 1: Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient and service user safety and patient and service user centred care

3.2 In 2014 the GPhC began a review of its core standards for registrants – the *Standards of conduct, ethics and performance* – originally published in 2010. The GPhC consulted on draft revised standards (with the proposed title of *Standards for pharmacy professionals)* in April 2016 and expects to publish the revised standards later in 2016. We look forward to the seeing the outcome of this work.

Standard 2: Additional guidance helps registrants apply the regulators' standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centred care

3.3 The GPhC has guidance documents available to help registrants meet the standards required of them. The GPhC did not publish any new guidance during the period under review as there was no need for any specific guidance.

3.4 In our 2013/14 and 2014/15 performance reviews we reported on the GPhC's approach to the open display of medicines in pharmacies (also referred to as 'self-selection' as it would allow patients to self-select pharmacy medicines[9]) and its intention to develop guidance in this area. The requirement for, and publication of, guidance remains dependent upon the legislative changes we have referred to at paragraph 2.6. The GPhC maintains its position that self-selection is not permitted and will not be until appropriate public protection safeguards can be agreed and put in place.

Standard 3: In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European and international regulation and learning from other areas of the regulators' work

3.5 When developing, its revised *Standards of conduct, ethics and performance*, the GPhC engaged with stakeholders in a number of ways:

- By conducting a series of half-day public and patient focus groups in London, Cardiff and Edinburgh

[9] Pharmacy medicines do not require a prescription but can only be supplied under the supervision of a pharmacist.

- By publishing a discussion paper *Patient-centred professionalism in pharmacy (April 2015)* in which it asked patients, pharmacy users, registrants and other stakeholders to contribute to a conversation about their expectations of professionals and what it means in practice
- By commissioning a research agency to work with patients and pharmacy professionals to explore options for the title of the new standards, following feedback about the current title.

Standard 4: The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed

3.6 There have been no changes to the way the GPhC publishes its standards and guidance on the dedicated section of its website. We therefore consider that the Standard continues to be met.

4. Education and Training

4.1 The GPhC has met all of the *Standards of Good Regulation* for Education and Training during 2015/16. Examples of how it has demonstrated this are set out below.

Standard 1: Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process

4.2 The GPhC continued with its review of its standards on education and training for pharmacists and pharmacy technicians. As part of this work the GPhC:

- In June 2015 published a discussion paper *Tomorrow's Pharmacy Team* setting out its conclusions about the future role of the pharmacy team and seeking feedback on its new approach to reviewing the standards by producing a single set of standards for the pharmacy team rather than maintaining separate standards for pharmacists and pharmacy technicians as is currently the case
- Held a stakeholder conference in November 2015 to consider the future of pharmacy education and training
- In December 2015 published the findings of research it had commissioned to analyse the existing *Standards of initial education and training for pharmacy technicians* and assess their fitness for purpose. The research report concluded that all of the existing standards were considered to be essential and made a number of suggestions and

recommendations, such as including more guidance on the code of conduct. The report also suggested that the education and training standards for pharmacy technicians should mirror those for pharmacists.

Standard 2: The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration

4.3 There were no significant changes to the GPhC's processes for quality assuring education programmes in 2015/16.

4.4 To register as a pharmacist with the GPhC, pharmacy graduates must complete a pre-registration training programme and pass the pre-registration assessment. The assessment is set and moderated by a Board of Assessors which is independent of the GPhC. The Board reports on outcomes of each assessment sitting (there are two each year) to the GPhC's Council. In June 2015 the report highlighted three continuing trends. We set these out below together with the GPhC's response to the issues:

- Pass rates were volatile and the pass rate in June 2015 was lower than in previous years. The Board was satisfied that the paper and the pass rate were at the right level. Learning points are shared with education providers and candidates and published after each sitting, and for the first time after the June 2015 sitting the learning points included some of the questions from the paper to assist with understanding the learning points. The GPhC also published information about how the paper is set and moderated
- Candidates who identified and declared as Black-African performed the least well. In October 2015 the GPhC commissioned qualitative research to explore why this might be. The research report, which was published in June 2016, concluded that the factors behind this were complex and wide-ranging. The report made suggestions for how education providers (both schools and pre-registration training providers) and the GPhC might look at addressing some of the issues. The GPhC plans to hold a seminar with key stakeholders in October 2016 to take this work forward
- Candidates who completed their pre-registration training in community pharmacy setting performed less well than those who train in hospital settings, and this difference was particularly marked in the June 2015 assessment. This appeared to be supported by the results of the GPhC's pre-registration trainee survey (published in September 2015) which showed that trainees in hospital settings were more satisfied with their training than those in community pharmacies. The research report (above) found that the poor quality of community placements was a fundamental factor in differences in attainment, which needed better regulation and quality assurance.

4.5 The GPhC has committed to publishing more data and in May 2015 published a summary of registration assessment data – including by school – for the period 2011-14. It published the data for June 2015 in October 2015,

and will continue to publish data for the June sittings.[10] We welcome the GPhC's transparency in making this available. This trend of poorer performance by ethnicity has been identified in other health professions (and in education more widely)[11] and we consider that the GPhC's approach is an appropriate one, seeking to ensure it fully understands the issues to inform its response to them.

Action is taken if the quality assurance process identifies concerns about education and training establishments

4.6 During a routine reaccreditation of a Masters level degree course in April 2015, the quality assurance process identified concerns that:

- The education provider had reduced the course entry requirements during the clearing process to recruit more students and had failed to act when the GPhC raised concerns
- The provider proposed allowing some students a third attempt at a failed module. The GPhC did not consider this inspired confidence that the education provider would produce graduates capable of safe and effective practice.

4.7 As a result these concerns, the GPhC agreed with the education provider that it would withdraw from the reaccreditation process at that time, and a detailed action plan to address the concerns would be required before reaccreditation could proceed. Contingencies were considered in case the provider remained unable to address the shortcomings identified before the expiry of its existing accreditation to deliver the course.

4.8 We consider this to be an example of how GPhC takes action if concerns are identified.

Standard 4: Information on approved programmes and the approval process is publicly available

4.9 The GPhC continues to publish information on approved programmes. Details of the processes it uses to approve and quality assure programmes, together with programme approval reports, is available and easily accessible on its website. Therefore the Standard continues to be met.

5. Registration

5.1 The GPhC has met all of the six *Standards of Good Regulation* for Registration in 2015/16. Examples of how it has demonstrated meeting these six Standards are set out below each individual Standard.

[10] The second sitting is in September each year but the small amount of candidates at this sitting means there is a risk of candidates being identified from the anonymised data, and therefore the GPhC does not publish it.

[11] We reported on the General Medical Council's work to understand differences in educational attainment in our 2014/15 performance review report which can be found at http://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/performance-review-report-2014-2015.pdf?sfvrsn=10

Standard 1: Only those who meet the regulator's requirements are registered

5.2 We did not identify any evidence that the GPhC has added to its register anyone who did not meet its requirements for registration and therefore the Standard continues to be met.

Standard 2: The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving

5.3 The GPhC has not reported any significant changes to its registration processes and we note that the number of appeals continues to be low, with the GPhC reporting that two registration appeals were received in 2015/16 (at the time of writing these appeals have not yet concluded).

Standard 3: Through the regulator's registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions of their practice

Standard 4: Employers are aware of the importance of checking a health professional's registration. Patients, service users and members of the public can find and check a health professional's registration

5.4 As part of our performance review we checked of a sample of the entries on the GPhC's register. We did not find any errors or other evidence to suggest the GPhC's registers are not accurate or accessible and therefore these Standards continue to be met.

Standard 5: Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner

5.5 We have not identified any changes to the GPhC's approach to managing this risk. During 2015/16, the GPhC commenced criminal proceedings in respect of four individuals misusing a protected title. Criminal convictions were secured in three of these cases and the fourth case is ongoing.

Standard 6: Through the regulator's continuing professional development / revalidation systems, registrants maintain the standards required to stay fit to practise

5.6 In June 2015 the GPhC successfully completed the first five year cycle of reviewing all registrants' continuing professional development (CPD) records since CPD had become mandatory for all registrants in 2010. The GPhC commissioned an independent review, as well as carrying out an operational review, of the process for obtaining registrants' CPD records and reviewing them. Recommendations for improvements were made, for example, reviewing a sample of CPD records rather than reviewing all records. Implementing the recommendations will require the GPhC to make changes to its CPD framework, requiring a consultation.

5.7 CPD is an element of a continuing fitness to practise scheme that, as we reported in last year's performance review, the GPhC is developing and planning to implement during 2018. This year the GPhC has carried out user testing of a simplified CPD recording tool and also held online workshops for registrants to get involved with the development. In 2016/17 the GPhC is piloting the proposed continuing fitness to practise scheme, which will include elements of CPD, peer review and case studies. At the time of writing, the GPhC had recruited 1,000 registrants for this pilot.

6. Fitness to Practise

6.1 As we set out in Section 2, we identified concerns about the GPhC's performance against Standards 5 and 6 and carried out a targeted review. The reasons for this, and what we found as a result, are set out under the relevant Standards below. Following the review we concluded that both these Standards were met and therefore the GPhC has met all of the ten *Standards of Good Regulation* for Fitness to Practise in 2015/16.

Standard 1: Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant

6.2 The GPhC told us that it strengthened the 'raising concerns' section of its website by making the online complaint form more accessible and improving the information about the types of complaints the GPhC can and cannot deal with, the information the complainant needs to provide, and signposting to other more appropriate organisations to deal with the concerns raised. We have reviewed this information and do not consider it will deter complaints about fitness to practise being made to the GPhC.

6.3 In 2015/16 the GPhC's pharmacy premises inspection team (see paragraph 2.6) made 103 referrals about registrants to the fitness to practise team.

Standard 2: Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks

6.4 The GPhC has a Memorandum of Understanding with a number of organisations including the Care Quality Commission, the Medicines and Healthcare products Regulatory Agency, NHS Protect, the Healthcare Inspectorate Wales and Healthcare Improvement Scotland.

6.5 The GPhC reported that it referred 12 pharmacy professionals to the Disclosure and Barring Service and/or Disclosure Scotland during 2015/16.

Standard 3: Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation

6.6 In 2015/16 the GPhC completed a review of its guidance for decision-making panels and, following public consultation, published two key documents:

- *Good decision making: investigating committee meetings and outcomes guidance* (January 2016). This guidance sets out how the GPhC's Investigating Committee decides if a registrant has a case to answer when a complaint is made about them
- *Good decision making: fitness to practise hearings and sanctions guidance* (July 2015). This guidance sets out how the GPhC's Fitness to Practice Committee determines if a registrant's fitness to practise is impaired and, if so, guides the Committee on the appropriate sanction to be imposed.

We had some concerns about the guidance for the Investigating Committee. These are set out at Standard 5 for Fitness to Practise below. However, generally we welcome the publication of this guidance as it combine previously separate guidance for the Committees, and provides helpful information for members of the public and registrants, and ensures the GPhC's decision-making process is transparent.

Standard 4: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel

6.7 In our previous two performance reviews we expressed concerns about the time-lag between receiving a complaint and making a decision to issue an interim order. This suggested that there may be issues identifying and prioritising cases where there was a potential risk to the public if an application for an interim order was required to control the potential risk while an investigation was carried out. In 2013/14 the median time it took (for the GPhC) to obtain an interim order decision from receipt of complaint was 14 weeks. In 2014/15 it increased to 18 weeks. In 2015/16 the median time was six weeks. This is a significant improvement. The GPhC told us that this is as a result of focusing on improving timeliness throughout all stages of the fitness to practise process (we discuss this further under Standard 6).

6.8 The median time taken by the GPhC to obtain an interim order decision once it has been decided to seek an order has also improved, from three weeks in 2014/15 to just over two weeks in 2015/16.

Standard 5: The fitness to practise process is transparent, fair, and proportionate and focused on public protection

6.9 We were concerned about how the GPhC's Investigating Committee (IC) was making decisions to refer registrants to a final fitness to practise hearing, so we carried out a targeted review of this Standard.

6.10 In general terms, an investigating committee (or equivalent decision-maker, such as a case examiner) considering a fitness to practise allegation against a registrant will apply what is known as the 'realistic prospect test'. This has two components:

- Is there a realistic prospect of the facts alleged being found proved by a final fitness to practise committee? If not, the case should be closed;

- If the first test is met, is there a realistic prospect of the registrant's fitness to practise being found to be impaired by a final fitness to practise committee? If no, the case should be closed. If yes, the case should be referred for a final hearing.

6.11 In 2015 the GPhC consulted on a guidance document for its IC, including guidance on how the realistic prospect test should be applied. We responded to this consultation. In January 2016 *Good decision making: investigating committee meetings and outcomes guidance* was published and we noted that the guidance on the realistic prospect test now included an additional test that the IC should apply if the realistic prospect test was met: that the IC must consider whether a referral for a final hearing was a proportionate outcome.

6.12 We interpreted the guidance as introducing a new test, with the potential to result in lenient outcomes: the IC closing cases which should be referred to a final hearing. This was exacerbated by the fact that this test had not been included as an option in its consultation.

6.13 The GPhC told us that this test was not new and the IC had always applied it in the way described in the document. The GPhC also told us that its legislation (the Pharmacy Order 2010) did not prevent the IC from exercising discretion in cases where the realistic prospect test was met and the IC was not absolutely required to refer such cases for a final hearing.

6.14 We carefully considered the legislation and decision-making guidance for the GPhC together with that applying to the other regulators we oversee. Although the legislation is not consistent, each regulator does have similar but not identical approaches to the realistic prospect test set out in their guidance. Following this review we were able to agree with the GPhC that its legislation did not prevent the IC from exercising this discretion. We also noted that other regulators have elements of discretion built into either their legislation or guidance, although none applied it in the same way as the GPhC.

6.15 We remained concerned that this additional test:

- Does not properly take into account the wider public interest in holding a public hearing when there is a real prospect of a registrant's fitness to practise being found to be impaired
- May result in lenient outcomes
- May damage public confidence in the GPhC as IC meetings are held in private and there is the potential for a perception to arise that serious cases are being shut down 'behind closed doors'.

6.16 However, the GPhC told us that between February 2016 (when the guidance was introduced) and the end of May 2016 the IC had closed only one case where the realistic prospect test was met. This reassured us, together with the fact that we had not previously become aware of any concerns about IC decisions to close cases even though this additional test of proportionality has apparently always been applied. We therefore decided that our concern did not prevent the Standard being met.

6.17 We will look at the quality of IC decision-making when we next carry out an audit of the GPhC's fitness to practise process.

Standard 6: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders

6.18 We carried out a targeted review of this Standard as have previously expressed our concerns about the GPhC's failure to meet this standard – only meeting it once in 2012/13. There was also evidence of a continuing decline in the GPhC's statistical performance demonstrated in its dataset:

- An increase in the median time taken from receipt of an initial complaint to the final fitness to practise committee determination or other final disposal of the case – from 85 weeks in 2014/15 to 96.1 weeks for quarter 3 2015/16[12]
- An increase in the number of cases aged over 104 weeks, from 39 cases at the end of 2014/15 to 53 cases at the end of quarter 3 2015/16
- An increase in the number of cases aged over 156 weeks from nine cases at the end of 2014/15 to 15 cases at the end of quarter 3 2015/16.

6.19 Conversely, we noted that other dataset measures indicated improving performance:

- A reduction in the time taken from initial receipt of the complaint to the final investigating committee decision – from a median of 63 weeks in 2014/15 to 41.4 weeks for quarter 3 2015/16
- A reduction in the time taken from the final investigating committee decision to final fitness to practise committee determination or other final disposal of the case – from a median of 46.5 weeks in 2014/15 to 38.3 weeks for quarter 3 2015/16.

6.20 We asked the GPhC to explain why their performance in these areas had declined and to tell us how it is tackling these issues. GPhC disagreed with us and explained that what the data was actually demonstrating was the success of its strategy to focus on the disposal of the oldest cases whilst at the same time ensuring newer and incoming cases were managed efficiently to avoid further increases in the aged caseload. The GPhC told us that the increase in the overall length of time taken to dispose of cases was directly linked to the disposal of aged cases, and that the increase in the overall median timeframe was an inevitable short term consequence of this progress, as the age profile of these cases statistically skewed the median.

6.21 During the targeted review stage the GPhC identified that the dataset it provided had been inaccurate in its representation of the numbers of aged cases. The GPhC provided us with revised data for each quarter of 2015/16 and this demonstrated that, in fact, there had been a *reduction* in the number

[12] Quarter 3 is 1 October – 31 December 2015.

of aged cases – rather than the dramatic increase initially indicated by the dataset.

6.22 The progress the GPhC has made in disposing of aged cases is shown in this table:

Number of open cases (at the end of each year/quarter) which are older than:	2013/14	2014/15	2015/16			
			Q1	Q2	Q3	Q4
Cases older than 52 weeks	143	128	150	126	95	106
Cases older than 104 weeks	36	39	63	46	38	37
Cases older than 156 weeks	1	9	17	7	15	10

6.23 This table sets out the time taken to progress cases:

	2013/14	2014/15	2015/16
Median time from initial receipt of complaint to the final investigating committee decision (weeks)	45	63	48.4
Median time from final investigating committee decision to the final fitness to practise committee determination or other final disposal of the case (weeks)	35	46.5	34
Time from receipt of initial complaint to final fitness to practise committee determination/or other final disposal of the case (weeks)	97	85	96.6

6.24 We can therefore understand and accept the GPhC's explanation for the increase in the overall time to conclude cases. So, in spite of this increase, taking account of the other measures which show an overall improvement in the GPhC's performance, we consider the Standard to be met.

6.25 We expect that that the overall time taken to conclude cases will start to improve as the number of open aged cases continues to decline. We acknowledge that the full impact of the GPhC's efforts to improve its performance in this area will take some time to show up in the dataset. Therefore we will continue to monitor this and encourage the GPhC to continue with this improvement.

Standard 7: All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process

6.26 As far as we are aware there have been no changes to the GPhC's target to update parties every two months and we have seen nothing to suggest that the GPhC is not keeping parties updated. We therefore consider the Standard remains met.

Standard 8: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession

6.27 We did not use our Section 29[5] powers to appeal any GPhC final fitness to practise decisions in 2015/16. We have not identified any concerns with the GPhC's decision-making in fitness to practise cases and therefore we consider the Standard continues to be met.

Standard 9: All fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders

6.28 As part of our performance review we checked a sample of the entries on the GPhC's register. We found nothing to suggest that the GPhC is failing to publish or communicate fitness to practise outcomes. Therefore the Standard continues to be met.

Standard 10: Information about fitness to practise cases is securely retained

6.29 In the 2014/15 performance review we reported that the GPhC told us it was working towards alignment with ISO27001:2013 certification, which is the international standard for information security management. This has not yet been achieved. Full alignment with ISO27001:2013 would provide a significant level of assurance that the GPhC's systems for identifying, classifying, reporting and remediating data breaches are robust.

6.30 We note that in 2015/16 the GPhC did not report any data breaches to the Information Commissioner's Office and therefore the Standard continues to be met.

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