General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

In person at Cabot square, Canary Wharf

7-16 January 2025

Registrant's name:	Shahid Hussain
Registration number:	2075141
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Sarah Hamilton (Chair) Esosa Osakue (Registrant Member) Stephanie Hayle (Lay member)
Secretary:	Zainab Mohamad (7-9, 14, 16 January) Adam Hern (10, 15 January) Gemma Staplehurst (13 January)
Registrant:	Present and represented by Paul Summerfield
General Pharmaceutical Council:	Represented by Matthew Corrie
Facts proved by admission:	1, 2.1, 2.2 ,2.3, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 4.5, 5, 6.1, 6.2, 7.1, 7.2, 8, 10.3, 11.1, 11.2, 11.3, 12.1, 12.2, 12.3, 13.1
Facts proved:	2.4, 2.5, 2.6, 2.7, 2.8, 6.3, 6.4, 6.5, 7.3, 7.4, 7.5, 9, 10.1, 10.2, 10.4, 11.4, 11.5, 11.6, 12.4, 13.2, 13.3, 13.4, 13.5, 13.6 and 14
Facts not proved:	15

Statutory ground:	Misconduct
Fitness to Practise:	Impaired
Outcome:	Suspension of 3 months with review
Interim Measures:	Interim Suspension order

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 14 February 2025 or, if an appeal is lodged, once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded.

Documentation

Document 1- Council's hearing bundle (1,842 pages)

Document 2 - Appendix 1 to Council's bundle

Document 3- Council's skeleton argument

Document 4- Witness statement of AP dated 19 December 2024

Document 5 - Excel spreadsheet High Risk Medicines

Document 6- Registrant's bundle (1,399 pages)

Document 7 - CA Testimonial

Document 8 - CA letter

Document 9 - Screenshot of GPhC website from November 2022

Document 10 - Risk assessment from IO bundle

Document 11 - BBC News online article 12 July 2022

Document 12 - BBC News online article30 September 2021

Document 13 - Blog " 2 years of Covid on GOV.UK - 25 July 2022

Witnesses

Dr GC, - Council's expert - gave evidence at facts stage

Ms SJ - Council inspector-gave evidence at facts stage

Mr AP- Council Inspection Operations Manager - gave evidence at facts stage

Mr Hussain, Registrant - gave evidence at facts and impairment stages

Mr M, Pharmacist - gave evidence at the impairment stage

Ms A MP - gave evidence at the impairment stage

Dr B- gave evidence at the impairment stage

Mrs ZK- gave evidence at the impairment stage

DETERMINATION ON FACTS

1. This is a Principal Hearing in respect of Mr Shahid Hussain, ("the Registrant"), a Pharmacist registered with the General Pharmaceutical Council ("the Council") on 18 October 2010 under registration number 2075141. The Registrant is present and represented by Paul Summerfield. The Council is represented by Matthew Corrie.

2. In advance of the hearing the Committee had read a statement of case and skeleton argument on behalf of the Council, together with the Council's bundle of evidence. The Committee also read the Registrant's statement of case, witness statement and written reflections, together with his bundle of evidence. The Committee heard oral evidence under affirmation from three Council witnesses and the Registrant also gave evidence under oath. The Committee heard oral submissions from Mr Summerfield and Mr Corrie.

3. This hearing is governed by The Pharmacy Order 2010 ("the Order") and The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010 "'the Rules").

4. The statutory overarching objectives for these regulatory proceedings are:
   - To protect, promote and maintain the health, safety and well-being of the public;
   - To promote and maintain public confidence in the professions regulated by the Council; and
   - To promote and maintain proper professional standards and conduct for members of those professions.

5. The Committee also had regard to the guidance contained in the Council's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.

6. A Principal Hearing has up to three stages:

- Stage 1. Findings of Fact – the Committee determines any disputed facts.
- Stage 2. Findings of statutory ground(s) and impairment – the Committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.
- Stage 3. Sanction – the Committee considers what, if any, outcome should be applied if the Registrant's fitness to practise is found to be impaired.

THE ALLEGATIONS (AS AMENDED)

7. The Particulars of Allegation, as amended, against the Registrant are as follows:

"You a registered pharmacist,

1. Whilst working for UK Meds Direct Ltd ("UK Meds") as a Pharmacist Independent Prescriber between approximately 21 September 2021 to 18 March 2022, you approved and/or prescribed approximately 36,312 prescriptions including those for high-risk medicines and/or medicines requiring ongoing monitoring.

2. In relation to 1 above, you failed to prescribe medicines, including approximately 5,070 prescriptions for high risk medicines, in accordance with and/or pay due regard to the relevant guidance on prescribing from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC") in that you prescribed in circumstances where you:

2.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing;

2.2. relied principally on the information received in an online questionnaire; 2.3. failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

2.4. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

2.5. failed to adequately consider the possibility of medication dependence and misuse;

2.6. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring;

2.7. failed to put adequate safety-netting in place; and/or

2.8. in relation to the high-risk medicines, knew or should have known that some patients had already made repeated orders for the same medicine from UK Meds; including, but not limited to, the medicines and the patients outlined in Schedule A.

3. In relation to 1 above, you entered into an agreement to prescribe and/or prescribed in circumstances where the UK Meds prescribing model or service was incapable of supporting safe prescribing decision in that:

3.1. no face-to-face or other virtual consultation took place other than the use of an online questionnaire;

3.2. patients were allowed to pre-select the medicine they desired;

3.3. patients provided information primarily through an online questionnaire; and/or

3.4. the service was not subject to appropriate regulatory oversight.

4. In relation to 1 above, you approved and/or prescribed the majority and/or a significant portion of prescriptions in circumstances where the time taken would not have been sufficient for you to clinically evaluate the suitability of the medicines to the patient including:

4.1. read, consider, and assimilate the completed online questionnaire;

4.2. consider if it was clinically necessary to check with the patients' GP and/or contact the GP;

4.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient;

4.4. consider if it was necessary to check the clinical background of the patient and/or check the clinical background; and/or

4.5. consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 2 above.

5. In relation to 1 above, you prescribed all or some of the medicines in Schedule B to patients in approximately the quantities outlined in the schedule on the basis of an online questionnaire, when they are unsuitable to be prescribed on that basis.

6. In relation to 1 above, on 14 October 2021, you prescribed Amitriptyline to Patient 1. In doing so, you:

6.1. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

6.2. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

6.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

6.4. failed to adequately consider the possibility of medication dependence and misuse; and/or

6.5. failed to put adequate safety-netting in place.

7. In relation to 1 above, on 1 November 2021 you prescribed Amitriptyline to Patient 57 based on an online questionnaire in which the patient informed that his diagnosis was "can use". In doing so, you:

7.1. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

7.2. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

7.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

7.4. failed to adequately consider the possibility of medication dependence and misuse; and/or

7.5. failed to put adequate safety-netting in place.

8. Between approximately 21 September 2021 and 18 March 2022, you worked as Superintendent Pharmacist and Responsible Pharmacist of Littleover Pharmacy, Derby dispensing and/or overseeing the dispensing of approximately 54,770 prescriptions for UK Meds.

9. In relation to 8, in September 2021 you entered into a business arrangement to prescribe and/or dispense medicines for UK Meds when you knew or ought to have known that they would not be subject to regulatory oversight by the GPhC or any other UK regulator.

10. You entered into the business arrangement in paragraph 9, without carrying out due diligence including assuring yourself that in relation to UK Meds:

10.1. that they were registered with an appropriate regulator;

10.2. that they were meeting the appropriate UK regulatory standards;

10.3. that their website was compliant with appropriate GPhC guidance; and/or

10.4. that the prescribing model that was used adequately safeguarded patients

11. In relation to 8 above, in your capacity as Responsible Pharmacist and/or Superintendent Pharmacist, you dispensed and/or oversaw the dispensing of high-risk medicines in circumstances where you had not assured yourself that they had been prescribed in accordance with the relevant guidance from the GMC, the RPS and the GPhC, in that they were routinely prescribed in circumstances where the prescriber had:

11.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing;

11.2. failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

11.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

11.4. failed to adequately consider the possibility of medication dependence and misuse;

11.5. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

11.6. failed to put adequate safety-netting in place.

12. In relation to 8 above, you dispensed and/or oversaw the dispensing of prescriptions in circumstances where the UK Meds prescribing model or service was incapable of supporting safe prescribing decision in that:

12.1. no face-to-face or other virtual consultation took place other than the use of an online questionnaire;

12.2. patients were allowed to pre-select the medicine they desired; 12.3. patients provided information primarily through a questionnaire; and/or

12.4. the service was not subject to appropriate regulatory oversight.

13. In relation to 8 above you dispensed/oversaw the dispensing of medicines in circumstances where you:

13.1. failed to have in place and/or carry out sufficient risk assessments to safely manage the risks of supplying medicines online;

13.2. failed to carry out sufficient audits to assure yourself that the service was operating safely;

13.3. failed to have in place adequate standard operating procedures or internal policies to manage the risks associated with supplying medicines online;

13.4. failed to have in place an adequate agreement setting out how GPhC standards would be maintained;

14. Your approach to prescribing and/or dispensing in all or some of the allegations 1 to 7 and 10 to 13 was transactional in that you were processing patient requests, that had been prescribed either by yourself or others, by reference to a patient completed an online questionnaire rather than in accordance with UK prescribing guidance.

15. Your approach to dispensing identified in all or some of the allegations 8 to 13 lacked integrity in that you placed financial gain over and above the interests of patients.

By reason of the matters set out above, your fitness to practise is impaired by reason of your misconduct."

Schedule A

Date(s) approved registrant	*Medication approved by the registrant*	*Patient Customer ID/ Patient No.*	*No. Approximate number of by the times the medication was previously prescribed via UK Meds by the registrant or another prescriber*
27 September 2021	*Amitriptyline*	*100035*	*16*
7 January 2022	*Amitriptyline*	*100035*	*17*
14 October 2021	*Amitriptyline*	*55864*	*17*
22 November 2021	*Amitriptyline*	*69090*	*14*
8 March 2022	*Amitriptyline*	*69090*	*15*
15 February 2022	*Amitriptyline*	*427098*	*14*
5 October 2021	*Amitriptyline*	*266404*	*11*
15 December 2021	*Amitriptyline*	*266404*	*13*
4 February 2022	*Amitriptyline*	*266404*	*15*
8 March 2022	*Amitriptyline*	*266404*	*16*
29 December 2021	*Propranolol*	*144565*	*4*
9 February 2022	*Propranolol*	*144565*	*5*
2 November 2021	*Propranolol*	*162412*	*7*
3 December 2021	*Propranolol*	*162412*	*8*
17 November 2021	*Propranolol*	*284498*	*6*
4 January 2022	*Propranolol*	*284498*	*7*
9 February 2022	*Propranolol*	*284498*	*8*
8 March 2022	*Propranolol*	*284498*	*9*
25 November 2021	*Propranolol*	*4001*	*23*
16 December 2021	*Propranolol*	*4001*	*24*
10 March 2022	*Propranolol*	*4001*	*26*
15 October 2021	*Propranolol*	*176113*	*23*
15 November 2021	*Propranolol*	*176113*	*24*

31 December 2021	*Propranolol*	*176113*	*25*
22 February 2022	*Propranolol*	*176113*	*26*
3 November 2021	*Carbamazepine*	*154433*	*11*
30 December 2021	*Carbamazepine*	*154433*	*13*
22 December 2021	*Carbamazepine*	*64731*	*5*
13 December 2021	*Orlistat*	*172755*	*30*
9 March 2022	*Orlistat*	*172755*	*31*
14 December 2021	*Orlistat*	*351084*	*8*
14 October 2021	*Amitriptyline*	*508912*	*1*
15 October 2021	*Amitriptyline*	*2202*	*13*
30 November 2021	*Amitriptyline*	*2202*	*15*
24 December 2021	*Amitriptyline*	*2202*	*16*
8 December 2021	*Amitriptyline*	*632043*	*2*
5 January 2022	*Amitriptyline*	*632043*	*3*
30 January 2022	*Amitriptyline*	*632043*	*4*
23 February 2022	*Amitriptyline*	*632043*	*5*
11 March 2022	*Propranolol*	*673993*	*1*
21 December 2021	*Circadin*	*255045*	*19*
31 October 2021	*Propranolol*	*119413*	*12*
25 January 2022	*Propranolol*	*119413*	*14*
6 March 2022	*Propranolol*	*119413*	*15*
8 December 2021	*Orlistat*	*566520*	*2*
29 December 2021	*Orlistat*	*566520*	*3*

Schedule B

Medicine	*Number of prescriptions (approx.)*
Amitriptyline	*944*
Propranolol	*3115*
Orlistat/Xenical and Saxenda	*623*
Promethazine	*493*
Metformin	*694*
Ventolin	*3484*
Carbamazepine	*21*
Bendroflumethiazide	*59*
Levothyroxine	*263*
Finasteride	*986*
Sildenafil	*2630*

PRELIMINARY MATTERS

APPLICATION TO AMEND THE PARTICULARS OF ALLEGATION

8. At the start of the hearing Mr Corrie applied to slightly amend Schedule B to the Particulars of Allegation to remove 'SSRI antidepressant – Priligy" because priligy is not an antidepressant. The Council's expert witness Dr GC makes no mention of priligy in her reports. The Council submitted that this amendment would not prejudice the fairness of the proceedings and properly reflects the current evidence contained within the bundle. The application was made under Rule 41 of the Council's (Fitness to Practise and Disqualification Rules) Order of the Council 2010 ("the Rules").

9. Mr Summerfield had been put on notice of this proposed amendment and made no objection.

10. The Committee agreed to the proposed amendment, noting that this was fair and better reflected the evidence in this case.

APPLICATION FOR THE HEARING TO BE HELD PARTLY IN PRIVATE

11. Mr Summerfield made an application for those parts of the hearing which related to his client's health and private family matters to be heard in private, pursuant to Rule 39(3).

12. Mr Corrie confirmed that the Council did not oppose this application.

13. The Committee agreed to move into private session when discussing matters pertaining to the Registrant's health and private life in order to protect his privacy. The remainder of the hearing would be in public.

ADMISSIONS

14. At the start of this hearing Mr Summerfield confirmed that the Registrant admitted Particular 8 of the Allegation and the Committee therefore announced that part of the Allegation proved by way of admission in accordance with the Rules.

15. During the course of the Council's evidence Mr Summerfield confirmed that having reviewed the evidence, the Registrant also admitted Particular 1, so the Committee also announced this as proved by way of admission.

16. Whilst the Registrant was being cross-examined he told the Committee that he had reflected and wished to make some more admissions. The Committee waited until he had been released from his oath, so he had an opportunity to consult with Mr Summerfield, who then confirmed that the Registrant wished to admit Particulars 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 4.5, 5, 6.1,

6.2, 7.1, 7.2, 10.3, 11.1, 11.2, 11.3, 12.1, 12.2, 12.3, and 13.1. The Committee therefore announced all of these proved.

BACKGROUND

17. Mr Corrie opened the case for the Council. Helpfully there was a detailed summary of the background to this case in the Council's skeleton argument. UK Meds began operating in October 2017, and provided an online pharmacy service. The Registrant prescribed for UK Meds Ltd between September 2021 and March 2022. The Registrant was a qualified pharmacist independent prescriber ("PIP"). He was engaged as a self-employed, third-party contractor by UK Meds, to provide prescribing and dispensing services. The Registrant was not at any time employed as an employee of UK Meds Direct.

18. At the time of the allegation UK Meds was an online pharmacy that used PIPs to issue prescriptions for patients who had selected their medicines, dosage and quantity from the website and then completed an online questionnaire that was electronically submitted. The completed questionnaire could be then reviewed online by a PIP. Having reviewed the questionnaire, the PIP's options were to 'Approve' the order and to issue a prescription for medicines, to 'Refuse' the order, or to 'Refer' the order to the UK Meds clinical leads for further consideration. When a PIP issued a prescription, it was then sent to the Pharmacy to be dispensed.

19. The Council obtained a written statement from AM, Lead Case Officer at the Council, dated 2 January 2024, which was agreed by the Registrant so she was not required to give oral evidence at this hearing. AM confirmed that UK Meds had been registered with the Council to operate an online pharmacy between 3 August 2017 and 7 September 2021. During this period of time, it came to the Council's attention that the systems at UK Meds were not safe, which led to UK Meds failing their standards during a Council inspection on 3 September 2019. On 8 November 2019, a Notice of Conditions was issued by the Council, preventing UK Meds from supplying controlled drugs and modafinil. On 9 March 2021, by way of a further Notice of Conditions, the Council added amitriptyline to the list of the medicines which UK Meds could not supply. Finally, on 30 July 2021

a further condition was imposed in that "*The pharmacy must not signpost or facilitate the direction of people to third party prescribing services that are not registered with a UK regulator."*

20. Following the conditions being imposed, UK Meds de-registered from the Council on 7 September 2021 and started operating as an online prescribing service, which was not subject to regulatory oversight. Instead, it engaged self-employed PIPs (including the Registrant). Around that time, UK Meds also started using community pharmacies to dispense medicines against prescriptions approved by UK Meds' third party PIPs. Littleover Pharmacy, 141 Rykneld Road, Littleover, DE23 4AL ("the Pharmacy") was one of the community pharmacies to whom UK Meds outsourced dispensing of medicines. The Registrant was also the Superintendent Pharmacist ("SI") and sometimes the Responsible Pharmacist ("RP") at Littleover Pharmacy which dispensed prescriptions on behalf of UK Meds. The Registrant was also the sole director and shareholder in the company, owning 100% of its shares.

21. The SI has a statutory duty to oversee the retail pharmacy business, namely the keeping, preparing and dispensing of medicinal products, and this includes any systems, processes and policies which cover these activities. The RP also has a statutory role in the operation of a pharmacy, including obligations to establish, maintain and keep under review procedures designed to secure the safe effective running of the business. The RP must ensure that the system used by a pharmacy is safe before dispensing can take place. The RP is also legally obliged to ensure that the Standard Operating Procedures ("SOPs") and clinical policies are safe and effective enough to protect the health and well-being of patients and members of the public and ensure that they are followed.

22. In April 2019, the Council issued *Guidance for registered pharmacies providing pharmacy services at a distance*, *including on the internet.* ("the April 2019 Guidance"). Within the guidance, the introduction states:

"*This guidance explains what pharmacy owners should consider before deciding whether any parts of their pharmacy service can be provided safely and effectively at a distance (including on the internet), rather than in the traditional face-to-face way.*

As the pharmacy owner, you are responsible for making sure this guidance is followed. Everyone in the pharmacy team, including managers with delegated responsibility and the responsible pharmacist, should understand the guidance and be aware of their responsibilities to follow it. If the registered pharmacy is owned by a 'body corporate' (for example a company or an NHS organisation) you should make sure the superintendent pharmacist understands it should be followed.

23. The Council also relied on:

- The The Royal Pharmaceutical Society ("RPS"), prescribing competency framework (2016) ("the RPS Guidance")
- GPhC in practice: Guidance for Pharmacist Prescribers ("the November 2019 Guidance")
- The General Medical Council ("GMC"), Good practice in prescribing and managing medicines and devices (April 2021) ("the GMC Guidance")

WITNESS EVIDENCE

24. The Council produced six written witness statements which were agreed by the Registrant, so the authors were not called to give oral evidence. They were as follows:

- Dr JK - Consultant at University Hospitals Dorset
- Ms MA - GPhC Professionals Regulations Manager (Legal)
- Mr SO - GPhC Senior Data Analyst and Insight Manager
- Ms AM - GPhC Lead Case Officer
- Ms NR - GPhC Senior Clinical Advisor and Specialist Inspector
- Ms AR - GPhC Customer Services Team Operations Support Officer

DR GC

25. The Council called Dr GC as its expert. She has been a GP for around 35 years. She has never been a pharmacist or a PIP, and has never worked in a pharmacy, although she has mentored PIPs in the past. She had provided two reports to the Council dated 20 June 2022 and 15 May 2023. Dr GC gave

oral evidence in line with her reports. Her first report had the subject matter "*To provide an opinion on the approach to prescribing which operated at UK Meds Ltd, with particular reference to the safety of patients."* The second report had the subject matter "*Safety of Prescribing Prescription Only Medications from Information Provided by Patient Self-Reported Online Questionnaires and Potential Risk to Patients".*

26. Within her reports Dr GC stated that in the past five to six years she had written several reports for the GMC on a variety of topics including Remote Prescribing. She contributed to the GMC's updated Guidance on Remote Prescribing in 2020. Dr GC provided a useful summary to the background for her report, which read as follows:

"*The Council's concerns in this case…centre on a remote prescribing model operated by online pharmacies, which involve a questionnaire-based assessment operating through a web-based platform. The Council are currently investigating a large number of cases that involve online pharmacies. These companies often own a registered pharmacy premises and operate a website through which the prescribing and dispensing services are accessed. Members of the public access the website and complete an on-line questionnaire, supplemented in some instances by standardised self-reporting scales. The completed documentation is then passed to a prescriber who makes a prescribing decision. Where a prescription is issued, the medication is then dispensed and dispatched to the patient by post or courier. The Council are concerned that medication is routinely being prescribed and issued without any discussion with the patient and without any access to information from the patients GP or other objective evidence of their diagnosis or condition. These online pharmacies provide a wide range of medications which, include medicines liable to abuse, overuse or misuse, or where there is a risk of addiction and ongoing monitoring is important, and medicines that require ongoing monitoring or management. Prescribers do not have access to the patient's General Practice records.*

Patients are usually asked to consent to information being shared with their General Practitioner. The Council are concerned that, if consent to share data was refused, it is common for prescriptions to be issued, nonetheless. Although there is often a facility for prescribers to email or call patients,

there is evidence, gathered by the Council, that this happens very infrequently. The evidence obtained by the Council's Inspection teams has demonstrated that it is very common for medication to be prescribed and dispensed based solely on the completed questionnaire and without any discussion between prescriber and patient, or clinical lead and patient.

The Council are concerned that these systems present an inherently weak model that puts patients at risk of harm."

27. The second report commented on the practices of remote prescribing. Dr GC summarised her opinion as follows:

"*In my opinion, the model used by these online pharmacies is unsafe insofar as prescribing within the requirements and limits of the framework was not in accordance with the competencies as described in the Royal Pharmaceutical Society's Competency Framework."*

28. Dr GC warned against prescribing in situations where an online self-reported questionnaire is used, especially one which can prompt responses. She also highlighted the risks associated with a lack of face-to-face interaction between patient and prescriber, and a lack of access or interaction with the patient's own GP's notes.

29. Dr GC's first report, which related to UK Meds' operation, stated:

"*I have written a number of Expert Reports on remote prescribing and have had access to several different online questionnaires. These questionnaires tend to have YES/NO answers, drop down boxes, and rely wholly on a patient honestly and competently giving a full and clinically accurate account of their medication conditions and current prescriptions. Patients are often asked if they are seeing or have seen their own GP or a secondary care specialist, if they are currently under any investigations, the results of previous investigations, previous medications tried and current medication including frequency and dosage.*

It is not possible to see a patient's GP notes, assess capacity and competence, (through observation and history taking), examine patients to see if signs and symptoms stated fit the clinical history given, assess any possible drug interactions or addiction and mental health issues as the prescriber can only rely on the information in front of them which has been provided by the patient and therefore not corroborated.

In my opinion, the self-populated questionnaires do not give sufficient clinical information to allow for an adequate patient assessment. In order for such an assessment, in my opinion, the Clinician requires access to the medical records or a discussion with the patient's own GP/Specialist as well as potential face to face patient assessment to confirm current physical or mental health, by video-link or, at least, by discussion over the telephone.

In my opinion, prescribing from a questionnaire without a face to face consultation is not and cannot be in a patient's best interests as the prescriber does not have a full and complete clinical picture of the patient, only self-reported information. Therefore, the prescriber cannot assess the patient clinically, assess their emotional and mental health or have any kind of meaningful therapeutic dialogue with them.

In summary, while self-populating the questionnaire, a patient must :

- *Give their GP details*
- *Give consent for their GP to be contacted*
- *Give sufficient means of identification*
- *Not be allowed to choose their medication or quantity*
- *Not request medication before expected date of repeat*
- *Answer a number of mainly Yes/No questions around systematic enquiry and current health*
- *Evidence whether they have capacity issues*
- *State if they have addiction or mental health issues.*
- *States allergies*
- *State if pregnant*
- *State if have a diagnosis given to them by their GP or hospital specialist*
- *State any OTC medications taken*
- *State any prescribed medications and their effectiveness Complete any drug specific questionnaires*

- *Answer honestly.*

In my opinion, even with the most honestly self-populated answers, there is still insufficient clinical information to allow for any safe prescribing. There is no 2 way discussion, no access to medical records to corroborate statements or answers given, and no way of assessing or examining the patient.

In conclusion, in my opinion, a PIP, prescribing for UK Meds Ltd, lacked the ability to Assess the Patient, Identify Evidence-Based Treatment Options for Clinical Decision Making, Present Options and Reach a Shared Decision, Prescribe, Provide Information, Monitor and Review, Prescribe Safely, Prescribe Professionally, Improve Prescribing Practice and Prescribe as Part of a Team. Therefore, in my opinion, a PIP could not safely prescribe high risk medications or for chronic diseases, nor were they able to diagnose medical conditions and initiate treatment from the information given in the self-populated questionnaire as they could not adhere to the requirements of the prescribing framework."

30. In her oral evidence Dr GC said that the GMC guidance is extremely similar to the Council's April 2019 Guidance when comparing the responsibilities and duties of a GP and a PIP who are prescribing (including history taking and safety-netting). She said that in order to prescribe safely they both require the same information - "*a prescription is a prescription".*

31. Dr GC said that as a GP she would never prescribe from a self-populated online questionnaire alone due to the "*complete lack of dialogue with the patient".* She would also be concerned as she would not understand the patient, their medication history (including possible mental health and addiction issues) and would not have received informed consent from them. At the very least Dr GC would want the patient to give consent so that their doctor could be told what medication had been prescribed. She is of the opinion that this online model of prescribing is unsafe, and has come across cases where this model has led to patient deaths (although there is no such suggestion in this case).

32. In her oral evidence Dr GC said that although there is a suggestion that in some cases UK Meds would email the patient for more information before prescribing, ("*and any two way communication is a good thing"*) there was no access to GP records or Summary Care Records. She said that unless the prescriber had all of the information, including seeing or speaking to the patient, they would not have the full clinical picture (e.g. to see if the patient was already taking the medication). During cross-examination by Mr Summerfield, Dr GC said that in order to get an adequate clinical picture, the prescriber needs to know what the patient is complaining of, current symptoms, past medical and prescribing history, whether they have any allergies, how long they have been taking the medication, and any mental health or addiction issues.

33. Dr GC accepted that many of the drugs referred to in her report are not relevant to the present case (e.g. benzodiazepines, z-drugs and gabapentinoids), and she had not seen the spreadsheet of the Registrant's prescribing patterns.

34. During re-examination Dr GC confirmed that only some of the drugs listed in Schedules A and B are high risk medicines "*in the classic sense",* but all of them could still harm a patient if they were prescribed inappropriately. She also said that it was the responsibility of the prescriber to inform the GP about the supply, and this should not be left to the patient.

MRS SJ

35. Mrs SJ is an inspector for the Council and also gave oral evidence at this hearing. Her witness statement is dated 3 August 2023. In her oral evidence Mrs SJ said that she qualified as a PIP in September 2022; at the time of the inspection she had not yet started the PIP course.

36. Mrs SJ confirmed in her written evidence that she carried out a focused inspection of the Littleover Pharmacy on 2 March 2022. At the premises were Mr Ajun Toor (the RP) and the Registrant, who

was the SI. According to the RP log, the Registrant also regularly worked as the RP at the Pharmacy. Mrs SJ was told that Mr Toor had only recently started working at the Pharmacy.

37. Mrs SJ explained that the Registrant appeared to have three roles whilst working at the Pharmacy; as a sole director he had a responsibility to ensure it was meeting the Council's standards; as an RP he had to ensure that prescriptions were supplied appropriately; and as a PIP he had a duty to ensure that he prescribed medicines safely.

38. Mrs SJ said that before issuing a prescription, the PIP should ensure that they have all of the information that they require to prescribe safely. She said that according to Macleod's Clinical Examinations, 14th edition, the average length of a consultation in UK general practice is 12 minutes. She would expect that reviewing an online consultation form would take less time, but noted that this method of prescribing would not allow the prescriber to easily ask any follow up questions or react to the patient's body language cues. Mrs SJ said that there is no benchmark time for reviewing an online questionnaire but noted that the PIP would still have to review the patient's questionnaire answers, record the prescribing decision and any accompanying notes, ensure the patient's usual GP has been notified (if the patient had consented), or consider whether prescribing was appropriate (if the patient had not consented) and make a record of this, contact the patient by email or telephone if further information was required or contact the patient to provide additional counselling information or safety-netting.

39. Mrs SJ exhibited to her witness statement a file note following her inspection, which included the following:

- *"SH* [the Registrant] *said that whilst working in his role as a PIP, he emailed a clinical advisor at UK Meds if he had a question and they liaised with the patient or surgery, dependent on the query.*
- *The pharmacy team could not see the responses to the patient questionnaires, whether consent to contact the usual GP had been given, or whether anyone has contacted the GP to inform them of*

the supply. This meant that the Registrant did not ensure that the pharmacy was meeting section 4.2, managing medicines safely, of the GPhC guidance for registered pharmacies providing pharmacy services at a distance, including the internet, as the pharmacy could not provide assurance that the GP had been informed of the supply.

- *The guidance also stated that for medicines liable to abuse, overuse or misuse, or where there is a risk of addiction and ongoing monitoring it is important, that the pharmacy has assured itself that the prescriber has been contacted in advance of the supply being made and that the GP has confirmed the prescription is appropriate for the patient. Again, this could not be demonstrated during the inspection. SH said that all these additional checks were done by UK Meds or a prescriber before the prescription was received by the pharmacy. However, the pharmacy had no access to patients' records held by UK Meds to confirm it. The service provided by the pharmacy was simply a fulfilment service with the pharmacist doing a basic clinical check of the prescription which was limited to whether the dose and strength of the medication prescribed was suitable for the age and sex of the patient.*
- *SH stated that the pharmacy team would not have access to patient records or consultation notes when they dispensed an NHS prescription, and he did not see the difference between the prescriptions dispensed for UK Meds and NHS prescriptions.*
- *SH said that he wouldn't approve prescriptions during his work with UK Meds for what he considers to be 'high risk' and he gave examples of beta-blockers and Duloxetine being high risk.*
- *SH said that he couldn't view the details of the previous prescriptions that he had approved and did not maintain personal records. He said that UK Meds held this information, and he could ask them for a report if it was required.*
- *Whilst checking a sample of prescription records on the pharmacy computer, I noticed that the prescriber's justification for prescribing was the same for each record. I asked SH whether this was a free-type box for the prescriber to write specific details related to the questionnaires that they have reviewed, and he said that it was not. SH said that it was a pre-populated drop-down box and the justification that I saw was a standard reason to enter when he approved a prescription.*
- *The UK Meds website was not compliant with the GPhC distant selling guidance as it was treatment led, rather than being condition led. This meant that patients could choose the specific medication, the strength and the quantity that they required…SH confirmed that he had read the guidance and looked at the website but had not noticed that it did not comply."*

40. Mrs SJ confirmed in her witness statement that at the time of the inspection, the Registrant provided her with risk assessments for the private face-to-face prescribing service, however, these did not cover the work that he did with UK Meds. The Registrant was asked about specific risk assessments for dispensing prescriptions issued by UK Meds and he told her that the service was covered by the risk assessments that he had shown her. Mrs SJ said that the Registrant had not taken steps to reduce the risks involved with working with a third-party prescribing service to provide medicines liable to abuse, misuse or overuse using a prescribing service that was not registered with a regulator. She referred to the Council's 2019 guidance for online pharmacies which states:

    "*We expect you to make sure you do not work with online providers who are trying to circumvent the regulatory oversight put into place within the UK to ensure patient safety throughout the healthcare system."*

41. Mrs SJ confirmed that the risk assessments which the Registrant showed her were deficient in the following ways:

- They did not cover each of the medicines that were supplied by the Pharmacy for the prescribing service, including any risks or ongoing monitoring that the medication would require.
- They did not explain how staff communicate between the prescribing service and the Pharmacy.
- There were no separate risk assessments which related to each of the delivery methods, including counselling, delivery and failed deliveries.
- They did not consider the business's capacity to provide the dispensing service for the prescribing service and how that could impact on the other services the Pharmacy offered.
- There were no risk assessments relating to record keeping, the behaviour of the people that access the service and the technology used.

42. Mrs SJ stated that the lack of a thorough and meaningful risk assessment meant that the risks associated with the supply of high-risk medicines, using a prescribing service that was not subject to UK regulatory oversight, were inadequately reviewed and were not being suitably managed. She

said that safeguarding vulnerable patients should have been identified as part of a thorough risk assessment so that steps could have been put in place to reduce these risks.

43. During cross-examination Mrs SJ was shown a risk assessment dated March 2022. She had not seen this before, and noted that even if this was in existence on the date of the inspection, the Registrant had been operating as a prescriber, working with UK Meds since September 2021 without any risk assessment in place. The risk assessment document within the Registrant's bundle which is dated March 2022, contained many areas where the risk was graded as red. Mrs SJ said that it should have been done before the Registrant started prescribing in September 2021. If the Registrant had done a risk assessment prior to his work with UK Meds, Mrs SJ believes that he would have developed SOPs around the risks, and would have been prompted to carry out audits to ensure that the current risks were being managed appropriately. An audit would have picked up that the online questionnaire was treatment led as opposed to condition led.

44. During the inspection, the Registrant told Mrs SJ that no audits related to the Pharmacy's work with the prescribing service had been carried out. She said that audits and risk assessments are important evidence to demonstrate that the service was operating safely, and a pharmacy offering higher-risk services should have carried out more in-depth audits of the service. She would have expected to see an audit on prescriptions that had been refused and whether the clinical decision was recorded and the patient given appropriate counselling and signposting; an audit on feedback from the people that were using the service; and an audit on the delivery service to ensure prescriptions were arriving safely and securely. As this was a relatively new service for the Pharmacy she would have expected the Registrant to be continuously reviewing and auditing how the new service was running.

45. Mrs SJ found that the SOPs provided during the inspection were not personalised to the Pharmacy and appeared to be SOPs written for the prescribing services of UK Meds, which was no longer registered with the Council. A copy of SOPs for partner pharmacies was supplied two days after the inspection, however, it was unclear to Ms SJ which SOPs the Pharmacy team were using at the time

of inspection as they were not available at the time. Mrs SJ explained that risk assessments are linked to SOPs as the processes described in the SOPs should address the risks identified in the risk assessments - "*If there's no risk assessment, you can't have a meaningful SOP".* She would generally expect to see the content of the SOPs to be updated as risks were identified and as the Pharmacy introduced new pharmacy services.

46. Mrs SJ was provided with a copy of the service level agreement ("SLA") in place between UK Meds and Littleover Pharmacy but noted that it did not make clear the accountabilities and roles and responsibilities of each party in relation to the Pharmacy meeting the Council's standards and guidance. For example, the SLA should have covered important points such as whether the prescribing service or the Pharmacy would notify the patient's usual prescriber about the supply, whether the prescribing service or the Pharmacy provided counselling and signposting information to the patient, and what would happen when medicines could not be delivered by the courier. Mrs SJ said that in practical terms it did not matter to her who notified the GP (either the prescriber or the Pharmacy) as long as it was done.

47. Mrs SJ had concerns regarding the repeated supplies of amitriptyline, which is a tricyclic antidepressant with several uses including neuropathic pain and migraine prophylaxis. It is a sedative and is known to be abused or misused for its sedative qualities. For example, Mrs SJ identified that Customer ID number 2022 received repeated supplies of amitriptyline. They were supplied six times at four-weekly intervals and it was unclear during the inspection whether their usual GP had been informed. The Council's guidance states that this medication should only be supplied online if there are additional safeguards in place such as the patient having given consent for their usual GP to be informed of the supply, and the Pharmacy should have confirmation that the usual GP had been contacted by the prescriber prior to the supply being made and confirmation that the supply was appropriate for that patient. There was no evidence to show that this confirmation had taken place at the Pharmacy and there was a risk that the patient was seeking medication that was not suitable for them.

48. With regards to amitriptyline, Mrs SJ said usually a patient would obtain this on repeat prescription from their GP. If a patient was trying to obtain this medication privately online, Mrs SJ would question whether this was because a GP had already made a decision that it was inappropriate to supply.

49. Another example of repeat supplies was for customer ID number 545475 for promethazine which is an antihistamine with several uses, such as travel sickness. It was listed on UK Meds website as treatment for hayfever and allergies, although Mrs SJ said there are other non-sedating antihistamines that are usually recommended when there is a face-to-face consultation at a community pharmacy. As promethazine is a sedative and liable to abuse, overuse or misuse, the Council's guidance states that it should only be supplied online if there are additional safeguards in place (the same safeguards as listed for amitriptyline above). Mrs SJ said that pharmacy staff working in a community pharmacy are trained to recognise that patients requesting sedatives such as promethazine on a regular basis may be abusing, misusing or overusing them and refer to the pharmacist. This safeguard was not available with the online prescribing model.

50. A third example given by Mrs SJ in her witness statement was in relation to the supply of four courses of metronidazole, an antibiotic used to treat bacterial vaginosis ("BV"). The first three courses were prescribed within a short time period, and then another course four months later. It was unclear whether any interventions had been made to confirm the diagnosis. Mrs SJ said that if the initial treatment did not work, it may have been due to an incorrect self-diagnosis, poor adherence with the treatment or a strain of the infection that does not respond to this antibiotic. She believes that an intervention by the prescriber or the Pharmacy, or referral to a GP for further investigation would have been appropriate in this case. Disclosure from UK Meds on 31 May 2023, showed that the patient actually received 10 courses of this antibiotic within a two-year period up to February 2022. Her usual GP was informed of a supply being made in February 2021 and no response was recorded. Mrs SJ would expect the prescribers to have identified that the frequency of prescriptions was concerning and to have referred the patient to her usual GP for further investigations as there could be a misdiagnosis. BV is usually diagnosed as a differential diagnosis which means that there are other infections or conditions that the patient could have had, for

example candidiasis, chlamydia, genital herpes, atrophic vaginitis or malignancy. Mrs SJ said that this suggests that the prescribing service that the Pharmacy had partnered with were issuing prescriptions that may not have been appropriate for the patient and the Pharmacy had not identified this through audits.

51. In terms of safety-netting, Mrs SJ said that she saw some comments "*at the back end of the system"* regarding having regulator blood pressure checks, but it was unclear how that information was relayed to the patient. She was critical of the pre-populated drop down box for clinical justification, which did not allow the Registrant to input free text. She said that this would be important especially where the Registrant decided to prescribe without the patient's consent to notify their GP. Mrs SJ was also concerned that the questionnaire was treatment led, whereas the Council's guidance makes it clear that it should have been condition led.

52. During cross-examination Mrs SJ was asked about the due diligence undertaken by the Registrant. She said that the Registrant had told her colleague that he had checked the UK Meds website in August 2021, and at that stage information such as the conditions it had imposed on it by the Council would still have been visible. The Registrant has produced a document called "*Due Diligence Checklist - Online Prescribing"* which states "*Completed 30 August 2021 Reviewed 6 March 2022"*. Mr Summerfield said that the Registrant completed this on 30 August 2021 and the text "reviewed 6 March 2022" meant that it was due to be reviewed on that date. One section stated "*Checked on the GPHC register and in good standing - YES - Previous GPhC inspection history checked RE controlled drugs – informed no CD's, opiates or Z drugs".* Mrs SJ was of the opinion that if proper due diligence had been carried out, it would have shown that UK Meds was not of good standing as of 30 August 2021, as its website would have confirmed that it was subject to conditions and improvement notices. She queried the sufficiency and efficacy of this document.

53. Mrs SJ said that after UK Meds deregistered on 7 September 2021 it became an unregulated entity, and was therefore very different from other prescribing services such as a GP surgery, which is regulated by the CQC. She said that CQC inspections look at the quality of consultations, patient

records, safety netting and interventions, whereas there were no such safeguards in place for UK Meds.

54. Another of Mrs SJ's concerns was that all of the staff at the Pharmacy other than the Registrant (in his role as the prescriber) did not have access to UK Meds systems, so all they could see was the name, address, date of birth and sex of the patient; there was no opportunity for any meaningful clinical intervention.

55. During cross-examination Mrs SJ was asked about the prescriptions from UK Meds where the Pharmacy was dispensing the medication (Particular 8). She said that in circumstances where UK Meds was not regulated, it was the Pharmacy's responsibility (including the SI and the RP) to ensure that the medication being supplied was safe, and this was not possible without access to the patient's medical records and no form of consultation. Mrs SJ said that it was the Registrant's choice to work with a prescribing service which was not regulated, and as the pharmacy owner/SI, he should have assured himself that the prescribing was appropriate, and that consultations were taking place. Instead, he was "*blindly sending out medication".* She relied on the April 2019 Guidance which stated that pharmacy owners must assure themselves that prescribers will proactively share all relevant information.

56. Ms SJ said that clearly the system had broken down, as otherwise Patient 1 (discussed below) would not have been able to obtain amitriptyline, when her GP had asked that she not be prescribed any more of the medication due to previous overdoses and mental health issues. Mrs SJ accepted that there is no evidence that the Registrant's issuing of one prescription caused actual harm to patient 1.

57. Finally, Mrs SJ confirmed that the condition prohibiting the Pharmacy from being involved in online prescribing was removed from the Pharmacy in November 2023 because the Registrant had assured the Council that he would never be involved in online prescribing in the future.

FURTHER APPLICATION TO AMEND THE PARTICULARS OF ALLEGATION

58. Mrs SJ concluded her oral evidence on day one of the hearing. On day two Mr Corrie applied to withdraw Particulars of Allegation 13.5 and 13.6, to reflect Mrs SJ's evidence. Mr Summerfield made no objection to this.

59. In relation to Particular 13.5, this read "*did not, at all times, have a second pharmacist assessing for accuracy and clinical appropriateness;".* Mrs SJ said that on the day of the inspection there was a second pharmacist on duty (Mr Toor). She could not say for certain whether there was always a second pharmacist working with the Registrant, although she did not believe this to be the case. However, the Council has not provided any documentary evidence to prove that there was not a second pharmacist present each day (the Registrant's position is that there always was a second pharmacist on duty). In light of this, the Committee agreed that Particular 13.5 should be withdrawn, as there was no reasonable prospect of the Council proving this allegation, as the evidence did not support it.

60. Particular 13.6 reads "*did not retain private prescription records in the pharmacy."* Mrs SJ had given oral evidence that the private prescription records did not need to be physically kept in the Pharmacy, as long as they were available. She confirmed that they were available from UK Meds. She was concerned that they could be altered, but that is not what this Particular alleges. Her evidence is that the records were retained, albeit not physically on the premises, and that is permitted. In light of this, the Committee agreed that Particular 13.6 should also be withdrawn, as the evidence does not support the allegation.

61. Particular 13.3 originally read "*failed to have in place standard operating procedures or internal policies to manage the risks associated with supplying medicines online;".* Following the conclusion of Mrs SJ's evidence on day one, Mr Corrie applied to amend this allegation to insert the word "*adequate"* before the phrase "*standard operating procedures",* as Mrs SJ's evidence was that she

had been shown some SOPs, but they were not sufficient as they were for UK Meds, and not Littleover Pharmacy. Mr Corrie submitted that a regulatory committee is entitled to amend an allegation and is under a duty to ensure that the case is not under-prosecuted. He relied on the case of *PSA v HCPC & Doree (2017) EWCA Civ 319* which held that a committee could agree to a retrospective amendment as long as this does not cause unfairness or prejudice to the Registrant.

62. Mr Corrie confirmed that Mrs SJ was available to be re-called to give further evidence on this point, and importantly be cross-examined by Mr Summerfield.

63. Mr Summerfield opposed this application on the basis that it would cause undue stress for Mrs SJ and for the Registrant. He said that the Council should not be given a *"second bite of the cherry".*

64. The Committee decided that it would allow the proposed amendment. It better reflected the evidence of Mrs SJ and did not make the allegation more serious. Mr Summerfield would be given time to take instructions from the Registrant before cross-examining Mrs SJ, and in those circumstances the Committee could not identify any real prejudice or unfairness to the Registrant.

FURTHER EVIDENCE OF MRS SJ

65. Mrs SJ was therefore re-called and gave further evidence under affirmation. She checked her emails and said that the Registrant sent her one set of SOPs on the morning of the inspection, on 2 March 2022 entitled "*UK Meds Direct Ltd Pharmacy Standard Operating Procedures"* and a second set two days later, on 4 March 2022, entitled "*Standard Operating Procedures for Partner Pharmacies.* Both of these were exhibited to her witness statement. The first set of SOPs which were signed by the SI for UK Meds, were dated 5 October 2020 and had a "next review date" of 5 October 2021. The second set were dated 7 September 2021 but were not signed and had no name attached to them to show who had approved them.

66. Mrs SJ said that the SOPs were appropriate and comprehensive for UK Meds, but were not adequate for Littleover Pharmacy. She said that even if the first set of SOPs was used, they were out of date as they should have been reviewed in October 2021. She would have expected to see a pharmacist's name on the second set - there was no indication as to who had drafted or approved them. She did not believe that she was shown a signature sheet by the Registrant to confirm that his staff had read the SOPs. She said that as far as she was aware, the SOPs were not available to the Pharmacy staff.

67. Mrs SJ maintained that the SOPs were not adequate for the Pharmacy. She gave example of references to the customer service team at UK Meds, and one SOP stating that all pharmacists had access to patients' details on UK Meds' system, whereas this was not true for the pharmacists at Littleover (other than the Registrant in his capacity as a prescriber).

MR AP

68. Mr AP was also called to give oral evidence on behalf of the Council. His witness statement is dated 19 December 2024. He is the Inspection Operations Manager for the Council. He gave evidence as to what one would see if they searched online for a particular pharmacy on the Council's website. He had exhibited to his statement a screenshot from December 2024.

69. Mr AP confirmed that on 31 August 2021, when the Registrant says that he searched online for UK Meds, this would have shown the following:

- Inspection report for the inspection dated 3 September 2019 which was published on 21 October 2019.
- Inspection report for the inspection dated 7 October 2020 which was published on 21 January 2021.
- An updated Enforcement Action Summary to include the Notice of Conditions dated 30 July 2021 which was published on 31 July 2021.

70. Mr AP said that the website changed in the past two months, and therefore it would have looked slightly different in August 2021. He was given time to provide a screenshot of what it used to look like and produced one from November 2022. This showed that it still had the box "Subject to Notices and Conditions". He said that the word YES would have appeared in that box, and if the Registrant had clicked on that word the list of Notices and Conditions which applied to UK Meds would have been visible. Likewise, there was a box for Enforcement Action.

THE REGISTRANT - MR HUSSAIN

71. The Registrant gave evidence under oath for two days. He started his career in Pharmacy at the age of 16, and trained with a pharmacy for eight years, through school, sixth form and university. He completed his MPharm degree in 2010. He moved to a new post in 2011 as a Senior Pharmacist Manager and managed over 15,000 prescriptions per month for five years. In 2017 he qualified as a PIP. He was appointed as the first Pharmacist in the country to work for NHS 111. Prior to working with UK Meds, he had worked as a PIP in different settings, but had never prescribed online before. In the majority of these other settings, he had had access to the patient's GP records before prescribing.

72. (REDACTED)

73. The Registrant said that he was first introduced to UK Meds by a patient, who knew one of the directors. There was an initial phone call, and then he went to a meeting with them in order to discuss the online prescribing service. The Registrant (REDACTED), and went back to work on a phased return on 22 August 2021. The meeting was set up for 30 August 2021 - he did not receive any paperwork from UK Meds before their meeting.

74. The Registrant said that he insisted on meeting the clinical team to gauge a better understanding of their system. He said he was adamant "*as a well-versed PIP and advanced clinical practitioner*" that he would not prescribe or dispense any controlled drugs, Z drugs or opiates whatsoever. He

had heard some online pharmacies had offered this service in the past and was aware that this was a high-risk area which he was not willing to entertain. The clinical leads said that there would be no option for these drugs to be prescribed or dispensed and they further reassured him that their focus was on "lifestyle treatments." During his four-hour meeting with UK Meds, the Registrant said that he was shown the Council's inspection report for UK Meds from 2019 and he read it in full. This report highlighted that the company had failed to meet a number of the standards, and that its online prescribing service was not safe. However, the Registrant said that he focused on the fact that as a result of that inspection UK Meds was prohibited from supplying opiates or controlled drugs, so in his mind the risks identified had been mitigated. During cross-examination he accepted that the inspection report should have been a red flag, putting him on notice that he needed to be especially vigilant when prescribing online with UK Meds. He also accepted that he was never asked by UK Meds to prescribe controlled drugs, opiates or Z-drugs.

75. The Registrant said that during the four-hour meeting he was given a comprehensive overview of the entire prescription journey, from patient consultation to medication dispensing. He observed how clinical leads were actively involved in the process, and that prescribers were empowered to decline prescriptions if deemed inappropriate, and to refer queries back to standby clinical leads. He said that there was a clear structure via email/online for contacting patients when additional follow-up was necessary, which he thought somewhat demonstrated a commitment to patient safety and ethical practice. Given that multiple pharmacies and pharmacists were already involved with working with UK Meds, "*working under strict regulatory oversight"*, the Registrant felt assured that supporting UK Meds in prescribing and dispensing during the pandemic was both the responsible and timely choice. In his written statement the Registrant had stated "*When Imet the clinical leads they explained to me in detail the prescription journey and almost had a supporting argument for every question I raised…when I questioned this their response was "Don't worry you won't have to deal with this that is our job as clinical leads – where we overlook every consultation that comes to your prescribing queue".*

76. The Registrant said that the clinical leads told him that registered medical doctors had created the patient questionnaires, anti-fraud checks were performed by a national company, and every

patient could be emailed with safety-netting. He was told that if they consented, summary care records could be requested.

77. The Registrant said he carried out due diligence on UK Meds on 30 August 2021 after he left their office. This was the first time he had been given any paperwork, and he never prepared a business plan. He checked to ensure that UK Meds was a registered pharmacy 0n 30 August 2021, and ensured that the clinical leads were registered with the Council. He also undertook a Companies House check to ensure that UK Meds was incorporated. In his oral evidence he said that he created the "Due Diligence" form on 30 August 2021 following the four hour meeting and reviewed it on 6 March 2022 following the Council's inspection. He said that he checked the Council's website regarding UK Meds but only saw one conditions notice prohibiting them from supplying controlled drugs/opiates and z-drugs. He denied that he saw any other notices, including the notice of 9 March 2021 prohibiting UK Meds from supplying amitriptyline, imposed due to "*ongoing systemic failures in the way the pharmacy manages the supplies of amitriptyline to some people and this presents a serious risk to patient safety."* He said that if he had seen this, he would never have prescribed amitriptyline. When cross-examined, he would not go as far as saying he would have refused to work with UK Meds at all, he still maintained that he would have done his "benefits versus risk" analysis and prescribed "lifestyle" medication such as treatment for asthma, diabetes and erectile dysfunction, weight loss medication and beta blockers for situational anxiety.

78. The Registrant said that he looked up UK Meds on the Council's website on 31 August 2021 and clicked on the YES button under notices/conditions, but the only condition there was the prohibition against supplying controlled drugs/opiates, which he already knew about from the four-hour meeting. He said that this reassured him, as UK Meds was no longer supplying these drugs, so he believed that the risks of online prescribing had automatically reduced. In cross-examination the Registrant said that if he had been told that UK Meds had deregistered from the Council in September 2021, he would not have agreed to work with them. However, he said that there was no need for him to check their status again following his initial check on 30 August 2021.

79. In his oral evidence the Registrant said that he carried out a risk assessment for the online prescribing in August 2021, and that following the inspection on 2 March 2022 he sent this to Mrs SJ (her evidence was that she was never provided with a risk assessment from 2021). The Registrant said that he would have kept a copy of his email to Mrs SJ enclosing the original risk assessment, but this was not provided to the Committee.

80. The Registrant said that he started working with the online pharmacy in September 2021. Initially he agreed to prescribe and for his pharmacy to dispense on a four-week trial. He could see that GP surgeries were struggling due to the pandemic. For example, patients were not able to obtain their Ventolin inhalers from surgeries on time. The Registrant recognised that there was another potential option for these patients in urgent need to access an online platform to obtain a Ventolin inhaler. He stated that "*my mindset at the time of reviewing these patient requests using the online platform was based on benefits versus risks.*"

81. The Registrant explained in his oral evidence that when the prescription requests came to him, they were already marked as green, amber or red. These colours were automatically allocated by the system depending on the patient's answers on the questionnaire. Green meant that the prescription request was *"ok*", amber meant there were concerns, and red meant that the medication should be refused. The Registrant said that he had no control over the traffic light system. The Registrant relied on the patient's declaration at the end of the questionnaire that they had answered all of the questions accurately and truthfully. The Registrant said that he referred around 30%-35% of the questionnaires (the amber ones) to the clinical leads - there were always two on standby. The clinical leads would then contact the patient and would then upload any information/documentation to the system so that the prescriber could review and decide whether to prescribe. The Registrant took the Committee through the prescription journey, explaining that as a PIP he could see the previous orders and notes from the clinical leads, but not any previous questionnaires for the patient.

82. The Registrant said that he usually worked 9am to 6pm, and over 50% of his time was spent dealing with UK Meds work. He had a pharmacy manager to deal with admin, and another pharmacist to deal with accuracy checking. There were always patient questionnaires in the queue on the system. The clinical leads told him that ideally the prescription request should be dealt with on the day it was received.

83. The Registrant gave evidence regarding Patient 1. The spreadsheet which was referred to in Mrs AM's statement (which was not challenged by the Registrant) shows that he prescribed amitriptyline to Patient 1 on 14 October 2021. In his oral evidence the Registrant said that the patient had not consented for their GP to be contacted, and that the entire questionnaire was coloured green (the consent box was always coloured green, even if the patient had not provided consent.) He said that all green on the questionnaire "*meant that it was ok to prescribe…it meant that the patient had been truthful with full knowledge and information".*

84. In his written statement the Registrant said that when he received the news about Patient 1 having had previous overdoses, and that her GP had informed UK Meds not to prescribe amitriptyline again, following an overdose in January 2021, he was "*shocked to the core*". He accepted that he had provided amitriptyline to a patient who had previously overdosed on the same medication (although he had not prescribed this as it was before his involvement with UK meds). UK Meds had been told of the overdose in February 2021 and one of the clinical leads should have put a red flag notice on the system but failed to do so. When the Registrant found out that the patient had not provided accurate information on their consultation, he realised the extent to which the online platform was dependent on trusting that patients are forthcoming about their conditions, their responses and medical history. At the time he expected patients to be truthful on their questionnaires. However, this incident highlighted to the Registrant why clinicians with responsibility should be meticulous when prescribing and dispensing medication on every occasion. The Registrant said that he was disappointed that UK Meds had not taken appropriate measures to alert him, nor did they add any alerts on the patient's record. His understanding and practice at the time was that any high priority notes were usually left on patient records if there was something that the prescribers needed to be aware of. The Registrant accepted that it was entirely

inappropriate to prescribe 56 tablets of amitriptyline to a patient who had a history of overdose and psychiatric illness. During cross-examination the Registrant accepted that patients can be manipulative, and that a face-to-face consultation would have provided him with an opportunity to look for clues. He accepted that the questionnaire for Patient 1 which he read had a number of red flags, including mention of a different email address, and two separate conditions. He agreed that he should have requested further information prior to prescribing, that he should have considered the risk of misuse/abuse of medication, and he should have refused the prescription request if the patient did not consent to contact her GP.

85. The Registrant spoke about the day of the inspection on 2 March 2022. He said that Ms SJ was much sterner than on previous inspections - "*she was on a mission".* He maintained that there was a sheet in the dispensary which had been signed by all 13 members of staff to confirm that they had read the SOPs, but this was not available to the Committee.

86. The Registrant stopped working with UK Meds in March 2022 following the inspection by Mrs SJ. He said that his relationship with the company was fine until December 2021, when the number of prescription requests being received from UK Meds increased (it had stopped using three or four other pharmacies by then). He had "*strong words"* with the company, and the volume reduced down again in January 2022, but UK Meds *"didn't take it too well".* In addition, he said that the clinical leads did not like it that he was sending through so many referrals. He told the company a week after the inspection that he was terminating their contract (around 10 or 11 March 2022), and put this in writing on 18 March 2022. In his written response the Registrant had told the Council that he had ceased working with UK Meds *"with immediate effect"* after the inspection. However, in his oral evidence he agreed that he had gone on dealing with high risk medicines prescription requests after 2 March 2022 whilst he was waiting to hear from Mrs SJ and his lawyers. He said that he referred every amitriptyline request to the clinical leads during this period (although the Committee noted that in fact on some he simply refused the request, and advised the patient to reorder a lower dose). During his evidence the Registrant said that he had faith and trusted the clinical leads, although he later said that it was a clinical lead who had failed to put the safety note on Patient 1's file, which caused him to lose faith in them.

87. During his oral evidence the Registrant said that he was unaware that UK Meds had removed itself from the register in September 2021. He only became aware of this when Mrs SJ told him at the time of the inspection on 2 March 2022. He felt let down, and thinks that UK Meds should have told him that they were no longer regulated by the Council.

88. The Registrant spoke about the volumes of prescriptions. He said that by January 2022 he was employing five dispensers and a pharmacist. He was being paid £3 per item by UK Meds (£1.50 for prescribing and £1.50 for dispensing if the prescription which he issued was also dispensed by Littleover Pharmacy - although some went to other pharmacies for dispensing). He was the sole owner, director and shareholder of Littleover Healthcare UK which owned the Pharmacy. He did not agree that he was putting profits before patient safety. He said that the reason he started the online prescribing service was as a response to his own experiences in August 2021 (REDACTED), and his desire to help patients who were struggling to get prescriptions from their GP.

89. The Registrant maintained that it is feasible and indeed reasonable to process a prescription online within two or three minutes. He also said that he had five dispensers and a pharmacist working full time. He maintained that taking an average of 2.6 minutes for each prescription approval (Ms AM's calculation based on the data) was a reasonable pace, as the patient questionnaire was already filled in, and "*a referral was just the click of a button".* Despite having been taken through many examples by Mr Corrie for several hours during cross-examination where the Registrant ultimately agreed that the prescribing was not in accordance with guidance, and created risks, overall the Registrant still denied that all of his prescribing was unsafe.

90. For the high-risk medicines listed in Schedule B, in his oral evidence the Registrant admitted that they were not suitable to be prescribed via an online questionnaire.

COUNCIL'S SUBMISSIONS ON FACTS

91. By the time that Mr Corrie provided his oral submissions on facts, the Registrant had admitted many of the Particulars of Allegation. Mr Corrie referred to the oral evidence of the witnesses and concentrated on the remaining particulars which the Registrant had denied.

92. Mr Corrie submitted that the Committee should give weight to Ms SJ's evidence as it is the most contemporaneous - her detailed file note was prepared shortly after the inspection. He said that she was an experienced inspector whose evidence was fair and balanced. Mr Corrie noted that Dr GC's evidence did not really appear to be challenged by the Registrant. Although she is a doctor as opposed to a pharmacist she is still a prescriber, and gave evidence that the principles for prescribing are the same for both professions.

93. Mr Corrie submitted that the steps taken by the Registrant before he started working with UK Meds were insufficient, and that the "Due Diligence" document was inadequate. He said that the four hour meeting, when all of the documents were handed to the Registrant for the first time, and website checks later that day were not enough; "due" meaning "a proper quantity or extent". This was particularly the case given that the Registrant had been told by UK Meds that they have been prohibited from supplying controlled drugs/opiates/z-drugs, and so was on notice that there had been previous issues. Mr Corrie submitted that these significant red flags highlighted the duty to look into UK Meds properly before starting to work with them. All the improvement notices/conditions for UK Meds were on the Council's website, and the Registrant now accepts that he should have read them.

REGISTRANT'S SUBMISSIONS ON FACTS

94. Mr Summerfield submitted that the Registrant had entered into his arrangement with UK Meds in good faith and good intentions in order to help patients access medication "*at the back end*" of a pandemic. He said that patients were still struggling to get GP appointments and medicines, and it was taking around four days to get a repeat prescription. He referred to his client's "*rather unique*

skill set" of being a PIP and an Advanced Clinical Practitioner, and a pharmacist for over a decade. He submitted that as a result of this experience the Registrant was able to prescribe quickly, transferring his skills to the online environment. The Registrant denies that he was a *"maverick"* prescriber, but asserts that he could glance at the questionnaire, assimilate the information, assess the risk and reach a decision very quickly.

DECISION ON FACTS

Particulars 1 - admitted

1. Whilst working for UK Meds Direct Ltd ("UK Meds") as a Pharmacist Independent Prescriber between approximately 21 September 2021 to 18 March 2022, you approved and/or prescribed approximately 36,312 prescriptions including those for high-risk medicines and/or medicines requiring ongoing monitoring.

95. The Registrant admitted this particular. The Committee has been provided with a spreadsheet showing the orders supplied by the Registrant. These started on 21 September 2021. The Committee also saw a copy of the contract between UK Meds and the Registrant, which is headed "seventh day of September 2021". Even in his own witness statement the Registrant stated that he started prescribing for UK Meds in September 2021.

Particulars 2.1-2.3 -admitted

2. In relation to 1 above, you failed to prescribe medicines, including approximately 5,070 prescriptions for high risk medicines, in accordance with and/or pay due regard to the relevant guidance on prescribing from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC") in that you prescribed in circumstances where you:

2.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing;

2.2. relied principally on the information received in an online questionnaire;

2.3. failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

96. Particular 2 relates specifically to the Registrant's work for UK Meds as a PIP. The Council produced the various guidance documents available to registrants in relation to undertaking pharmacy services at a distance. The Registrant accepted that they were all relevant to his prescribing.

97. In his oral evidence the Registrant said that he had read the Council's 2019 Guidance regarding online prescribing and had an overview of the GMC guidance, although had not read it in detail. Mr Corrie took him through the main principles outlined in the November 2019 guidance, and the Registrant accepted that a PIP had responsibility for prescribing safely, should have all the necessary information, assess the risk of prescribing and follow up and monitor patients. He accepted that the guidance stated:

"*In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber".*

98. The Registrant also accepted that the principles set out in the GMC guidance were relevant to PIPs. This include guidance that:

"*Circumstances in which a face-to-face consultation may be more appropriate than a remote consultation include when:...you are not the patient's usual doctor or GP and they have not given you consent to share their information with their regular prescriber; this is particularly important if the treatment needs following up or monitoring, or if you are prescribing medicines where additional safeguards are needed".*

99. The Council has obtained two expert reports from Dr GC specifically documenting the dangers in relation to online prescribing. Although Dr GC gave evidence that she would never prescribe online based on a questionnaire alone, the Committee acknowledges that this is not unlawful. However, PIPs must ensure that they are following UK prescribing guidance, including the principles set out in the GMC guidance, which advises against this method without any further safeguards. In his oral evidence the Registrant agreed with Dr GC that it is important to have objectively verifiable information to test the subjective information from the patient.

100. The spreadsheet of orders referred to above shows that the Registrant prescribed 36,312 prescriptions and that 5,070 of these prescriptions were for high-risk medicines. Of these, 2,777 high-risk prescriptions were dispensed at the Littleover Pharmacy. The remaining high-risk medicines he prescribed were dispensed through other pharmacies.

101. The Council obtained a witness statement from AM, Lead Case Officer, dated 2 January 2024. She undertook an analysis of the repeat orders made by patients using UK Meds website. Whilst the Registrant has provided some examples of him refusing to provide prescriptions (around 3%), the Council submits that these are relatively few in comparison to the prescriptions he prescribed, with no examples of the Registrant making attempts to contact a patient's GP or recommendations to UK Meds that a patient's GP be contacted. The Council noted that the forms indicate that the justifications given for prescriptions were nearly identical on each occasion.

102. During cross-examination Mr Corrie took the Registrant through many examples of where the Registrant had prescribed the high-risk medicines in Schedule A. One patient was prescribed ventolin every month, and each time they put on the questionnaire the reason for needing a prescription was that they had lost their inhaler. The Registrant accepted that losing medication once or twice would have been understandable, but to apparently lose the inhaler every month would be a red flag and was concerning. He agreed with Mr Corrie that there were pitfalls in the system, including that he could not see the questionnaires for the previous months. Likewise, he admitted that he had not paid proper heed to the cases where there were repeat prescriptions requests, for example one patient was prescribed amitriptyline on 18 occasions (two by the Registrant). The Committee noted that one of these approvals took the Registrant less than a

minute to process. Overall, the Registrant seemed to accept some pitfalls, but maintained that there were other elements of the system which were safe.

103. The Registrant said that following his assessment of information provided in each online consultation he "*appropriately refused or referred thousands of prescriptions."* He said that these referrals/refusals show that he was considering dependency issues in a meaningful way. He said that patient safety was always paramount to him in this role and in his mind he felt the refusal report demonstrated that he was engaging in clinical awareness and judgment, which prioritised patient safety. In his written statement the Registrant accepted that in some cases he should have been more vigilant and taken a more thorough approach. However, at times during his oral evidence he maintained that his prescribing was safe, and gave examples of when he had refused to prescribe to support that position. Following the inspection the Registrant was able to obtain a report from UK Meds showing how many prescription requests he refused. From September 2021 to March 2022 there were 182 requests for amitriptyline which were refused by the Registrant, (944 requests for amitriptyline were approved during this period according to the agreed evidence of Ms AM). The report from UK Meds also shows that 1,335 items in total were refused by the Registrant (which included amitriptyline). This is compared to the agreed evidence of Ms AM that during the same period 36,312 prescriptions were approved by the Registrant.

104. The Council's April 2019 guidance states that:

"*make sure your pharmacy staff can:*

- *get all the information they need from people receiving pharmacy services so they can check that the supply is safe and appropriate, taking into account, for example, their age, gender, other medicines and other relevant issues*

If you decide to work with an online prescribing service or prescriber, the above categories of medicines should not be prescribed unless the safeguards below have been put in place

- *the person has been asked for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription"*

105. The RPS prescribing competency framework, which the Registrant said he had read, states:

- *Takes an appropriate medical, social and medication history including allergies and intolerances.*
- *Accesses and interprets all available and relevant patient records to ensure knowledge of the patient's management to date.*

106. The Council's November 2019 Guidance states:

- *Having all the necessary information to prescribe safely*
- *"Pharmacist prescribers should assess whether they have sufficient information and knowledge of the person's health and medical history to make an assessment of the condition."*
- *"Pharmacists must ask the person for consent to access their medical records, or to get other reliable information about the person's health and medicines from their regular prescriber"*
- *In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber.*

107. The Registrant did not follow this guidance. He relied solely on the patient questionnaire, and did not have access to or request the patients' GP notes, which may have provided important information, to ensure that the prescribing was safe.

Particulars 2.4, 2.5, 2.6, 2.7, 2.8 - proved

2.4. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

2.5. failed to adequately consider the possibility of medication dependence and misuse;

2.6. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring;

2.7. failed to put adequate safety-netting in place; and/or

2.8. in relation to the high-risk medicines, knew or should have known that some patients had already made repeated orders for the same medicine from UK Meds; including, but not limited to, the medicines and the patients outlined in Schedule A.

108. The Registrant denied these particulars of allegation. Mr Corrie submitted that by the time of closing submissions on facts there was really no dispute as to the "prescription journey". He submitted that the process did not comply with the Council's guidance as the Registrant did not request a face-to-face consultation, did not refer patients back to their GP in circumstances where it was appropriate to do so, did not provide adequate safeguarding and prescribed high-risk medication to patients whom he knew or should have known had already made repeated orders for the same medicine from UK Meds.

109. The GMC guidance states:

"*Circumstances in which a face-to-face consultation may be more appropriate than a remote consultation include when:[…] you are not the patient's usual doctor or GP and they have not given you consent to share their information with their regular prescriber; this is particularly important if the treatment needs following up or monitoring, or if you are prescribing medicines where additional safeguards are needed"*

110. Mr Summerfield said that the Registrant agreed that the principles set out in the GMC guidance also applied to PIPs. The Registrant was prescribing high-risk medication to patients who did not consent to the sharing of information with their regular prescriber or GP. In those circumstances he should have had face-to-face consultations with the patient. If that was not available due to UK Meds' prescribing model, he should have refused to prescribe. This was not a situation which was "sprung" on the Registrant when he started prescribing - from his initial meeting with UK Meds in August 2021 he knew there was no facility for face-to-face consultations. It was his choice to nevertheless sign up to this system. Even though the Registrant said that he was assured because

he could refer cases to the clinical leads, they also did not have the facility for face-to-face consultations, so this "safeguard" was insufficient.

111. The Committee therefore finds Particular 2.4 proved.

112. In relation to Particular 2.5, the RPS framework provides:

"Identifies the potential risks associated with prescribing via remote media…and takes steps to minimise them…Minimises risk to patients by using or developing processes that support safe prescribing particularly in areas of high risk (e.g…prescription of repeat medicines)"

113. The Council's November 2019 Guidance states:

"*The pharmacist prescriber must then decide whether or not to prescribe. They will need to think about the person's best interests, make a risk based assessment about whether they can prescribe safely and make a clear record, setting out their justification for prescribing or not prescribing. Prescribing information should be shared with the person's prescriber, or others involved in their care, so the person received safe and effective care. Pharmacist prescribers should use their professional judgement when deciding what information to share. This is especially important when prescribing medicines that are liable to abuse, overuse or misuse, when there is a risk of addiction or when monitoring is ongoing.*

In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber. (High-risk medicines are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important.) Appropriate risk management and safeguards must be in place…

114. The GMC guidance states:

"*If you don't have access to relevant information from the patient's medical records you must not prescribe controlled drugs or medicines that are liable to abuse, overuse or misuse or when there is a risk of addiction and monitoring is important*"

115. The Registrant says that he did refuse requests or referred the patients back to the clinical lead when there was a risk of misuse or overuse. However, the spreadsheet of orders show that there were 5,070 prescriptions of high-risk medication issued by the Registrant, where he did not ask for or have access to the patients' medical records (because the UK Meds model did not allow for this). He was simply relying on the patient questionnaires or was referring the request to a clinical lead. The Registrant said that in some cases the clinical lead would come back with more information, but there is no evidence in the bundle to show that the clinical lead had seen the patient's GP records. The Committee considered that the Registrant was processing each prescription very quickly. At the rate he was prescribing, he would not have had time to properly assess the risk of misuse or overuse. Although the GMC guidance is issued for doctors, the principles also apply for pharmacists who are prescribing. The Registrant could not properly assess the risk of dependence or misuse when he did not have access to the relevant information from patients' medical records (e.g. if they had been prescribed the high-risk medication before, and if so how often).

116. Although there is evidence that the Registrant refused some requests for amitriptyline, he approved around 80% of such requests. There were no rigorous checks in place. The refusal spreadsheet which the Registrant produced did not really show why he was rejecting the prescriptions and is not evidence that he was adequately assessing the risks in each case. The Registrant also appeared to overlook the information which he did have (e.g. he was prescribing high risk medications each month such as ventolin or amitriptyline).

117. The Committee therefore finds particular 2.5 proved.

118. In relation to Particular 2.6, the Council's April 2019 Guidance states:

"for medicines which are liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, you have assured yourself that the prescriber has contacted the

GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the prescription is appropriate for the patient and that appropriate monitoring is in place

"Safeguards to put in place if the above categories of medicines are to be supplied online [includes high-risk medication]

- *the person has been asked for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription*
- *you have assured yourself that the prescriber will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)*
- *for medicines which are liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, you have assured yourself that the prescriber has contacted the GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the prescription is appropriate for the patient and that appropriate monitoring is in place*

119. The Council's November 2019 Guidance states that high-risk medicines should only be prescribed if the prescriber:

- *has asked the person for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription*
- *has contacted the GP in advance of issuing a prescription for medicines which are liable to abuse, overuse or misuse (or where there is a risk of addiction and ongoing monitoring is important) and the GP has confirmed to the prescriber that the prescription is appropriate for the person and that appropriate monitoring is in place*

120. The GMC guidance states:

" *If you are not the patient's regular prescriber, you should ask for the patient's consent to:*

a contact their GP or other treating doctors if you need more information or confirmation of the information you have before

prescribing

b share information with their GP when the episode of care is completed.

If the patient objects to information being shared with you, or does not have a regular prescriber, you must be able to justify a decision to prescribe without that information".

121. There is no evidence that the Registrant took any of these steps. He had no access to GP records, in the majority of cases the patients did not consent for their GP to be informed about the prescription, and there was no system for monitoring medication. GPs have to regularly review patients' repeat medication- the Registrant had no such system in place.

122. The Committee therefore finds Particular 2.6 proved.

123. In relation to Particular 2.7 (safety-netting), the Council's guidance states that the prescriber should:

"*tell the person that if their condition gets worse, or there are any new symptoms or changes in their condition, to come back to the pharmacist prescriber to make sure no serious conditions are missed (this is called 'safety netting')*

124. Within the Registrant's bundle there were around 820 pages of what the Registrant refers to as "safety-netting". This was a table of entries for patients with a comments section. In his evidence the Registrant explained that he would always add safety-netting advice, whether he approved or refused a prescription, and this would always include a hyperlink to a web address from either NHS UK or Patient UK. He said that he would have these websites open on his computer, so it took only up to 20 seconds to find the relevant page and then copy and paste the relevant hyperlink into the email which was sent to the patient.

125. Mr Summerfield submitted that this was extensive evidence of "safety-netting" advice which the Registrant gave to the patients, whether he approved or rejected their requests, including advice

regarding amitriptyline and propranolol. In addition, the Registrant's case is that he always included hyperlinks for additional information available online. The Registrant said that he would consult the necessary advice/ guidance and then copy and paste this into the safety-netting box. Most of the examples he provided had identical wording. Some examples did have the name of the website where further information could be maintained (the complete url address), although many did not make any such reference. The Registrant was adamant that a hyperlink was provided in each case, and it is simply the case that when UK Meds sent through this spreadsheet the hyperlinks were not visible.

126. Mr Summerfield submitted that there is a vast amount of documentary evidence before this Committee to show the attempts the Registrant made to mitigate the risks to patient safety. He relied on the refusal reports showing where the Registrant refused to prescribe and told the patient to go to their GP. The Registrant said that he referred thousands of prescriptions to the clinical leads, although there is no documentary evidence before the Committee to demonstrate this. The Committee did not find it plausible that the Registrant provided the safety-netting advice in every case - he estimated that it would have taken up to 20 seconds to find the correct webpage for the condition/treatment and then cut and paste the hyperlink. This would have left around 40 seconds to carry out all the remaining steps necessary, based on the agreed evidence that some prescriptions were processed in around one minute. It is more likely that in some cases the Registrant did not provide any safety-netting advice.

127. The Committee therefore finds Particular 2.7 proved.

128. In relation to Particular 2.8 the Council's guidance states that pharmacy owners should:

"*identify requests for medicines that are inappropriate, by being able to identify multiple orders to the same address or orders using the same payment details this includes inappropriate combinations of medicines and requests that are too large or too frequent".*

129. Mr Summerfield's initial written submissions were to the effect that the Registrant adhered to the Council and the RPS guidance, but he was not required to adhere to the GMC guidance as he is not

a doctor. However, by the time it came to closing submissions, the Registrant accepted Dr GC's evidence that the principles in the GMC guidance also applied to PIPs.

130. Mr Summerfield said that Particular 2.8 was denied because the Registrant did have access to the orders previously issued by UK Meds. In his statement of case Mr Summerfied submitted that the Registrant used his unique skill set and prior knowledge of NHS service delivery to ensure that the service was safe and effective.

131. Mr Corrie submitted that the Registrant in fact appeared to accept this allegation in cross-examination. The Registrant accepted that the order history was available to the PIP, and had accepted Ms AM's evidence of examples of lists of orders in relation to the specific patients, who were supplied on multiple occasions with medicines liable to abuse/misuse/overuse or requiring monitoring.

132. The Committee does not consider that the service provided by the Registrant was compliant with the various guidance. As the Registrant said himself, he was an autonomous prescriber, and it was his responsibility to ensure that patients did not receive repeat orders of high-risk medication without further safeguards being put in place (e,g, checking with the patient's GP first). Either he saw but did not take notice of the multiple previous orders issued by UK Meds, or did not look for them in the first place. This is likely taking into account the very short timeframe in which he issued each prescription.

133. The Committee therefore finds Particular 2.8 proved.

Particulars 3.1-3.4 - admitted

In relation to 1 above, you entered into an agreement to prescribe and/or prescribed in circumstances where the UK Meds prescribing model or service was incapable of supporting safe prescribing decision in that:

3.1. no face-to-face or other virtual consultation took place other than the use of an online questionnaire;

3.2. patients were allowed to pre-select the medicine they desired;

3.3. patients provided information primarily through an online questionnaire; and/or

3.4. the service was not subject to appropriate regulatory oversight.

134. These Particulars of Allegation relate specifically to the Registrant's work for UK Meds as a PIP. At the time of their working relationship, UK Meds had voluntarily removed itself from the Council's register as of 7 September 2021, and was therefore operating without regulatory oversight.

135. Although the Registrant was not employed by UK Meds, his role as a PIP was still to ensure that as a prescriber his professional judgement was not compromised and that he was able to perform his role safely and uphold his obligations as a registered pharmacist. He did not abide by the available guidance which would have enabled him to ensure he was working with a regulated pharmacy and a website which did not allow patients to select their medicine. The prescribing model did not have sufficient safeguards in place to permit the safe prescribing of medicines such as by information sharing with GPs or obtaining summary care records.

136. The guidance sets out that there are various medicines which are not suitable to be prescribed on the basis of an online questionnaire but need additional safeguards in place for general prescribing online, due to the increased risk profile. There is no evidence that the Registrant considered these risks and adapted his practices (for example by attempting to contact patients himself).

137. The Committee accepted Dr GC's opinion that a consultation is the main factor in ensuring safe prescribing, as it enables the prescriber to interview the patient to obtain all necessary information to determine their physical and mental health, as well as consider other relevant factors. Dr GC commented on prescribing without access to the patient's medical records, which she considers to be a vital element of the assessment of the patient. Dr GC stressed the importance of face-to-face consultations for all types of conditions and noted that particularly patients with ongoing pain would require regular face-to-face consultations to manage their conditions. Dr GC also considered

that if patient records cannot be assessed, then no medication can be safely prescribed without a face-to-face assessment.

138. The Committee has already explained in relation to Particular 2.4 why it was not safe to prescribe high-risk medication without a face-to-face or virtual consultation with the patient in circumstances when the only information the prescriber had was from the questionnaire, which relied upon the patient answering truthfully.

139. Mrs SJ's evidence was that the UK Meds website was not compliant with the Council's distance selling guidance as it was treatment led, rather than being condition led. This meant that patients could choose the specific medication, the strength and the quantity that they required. She said that there was a risk that the patient was not prescribed with the most suitable medication for their condition as they may not have known that there were alternatives. She said that it placed pressure on the prescriber to issue a prescription for the medication that the patient had specifically requested, rather than it being a joint decision between the patient and the prescriber.

140. The Registrant said that he was aware that there was guidance available which said that the requests for medication online should be condition led as opposed to treatment led. He spoke to UK Meds about this and they told him they were considering going back to a condition led approach (although this did not happen whilst he worked with them). Reflecting back now he accepts that he should have followed this issue up with UK Meds (and he therefore admitted this allegation). However, at the time he was satisfied overall that the UK Meds system was robust enough.

141. As UK Meds had de-registered from the Council by the time of these allegations, the Council did not have any oversight over the company. The company was simply providing an online prescribing service without any employed prescribers, so the company was not subject to any regulatory scrutiny.

Particular 4.1, 4.2, 4.3, 4.4 & 4.5 - proved

4. In relation to 1 above, you approved and/or prescribed the majority and/or a significant portion of prescriptions in circumstances where the time taken would not have been sufficient for you to clinically evaluate the suitability of the medicines to the patient including:

4.1. read, consider, and assimilate the completed online questionnaire;

4.2. consider if it was clinically necessary to check with the patients' GP and/or contact the GP;

4.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient;

4.4. consider if it was necessary to check the clinical background of the patient and/or check the clinical background; and/or

4.5. consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 2 above.

142. The Committee has been provided with two spreadsheets which contain the prescribing data processed through UK Meds' website, showing the exact time/date the consultation was submitted by the patient, the exact time/date the consultation was reviewed by the prescriber and the exact time the prescription was dispensed by the Registrant. There was also a column showing whether or not the prescribing information had been shared with a GP.

143. AM identified in her witness statement (which was not challenged by the Registrant), that between 21 September 2021 and 18 March 2022 the Registrant approved 36,312 prescriptions. The Council highlighted that on 717 occasions it can be seen that there was less than one minute between the order being created by the patient, then submitted to UK Meds, and the Registrant's approval. Additionally, on 29,886 occasions it can be seen that the Registrant approved prescriptions less than one minute after approving the previous prescription. The Council submits that it would not have been possible for the Registrant to consider all of the issues listed in Particulars 4.1-4.5 within that time frame. It is submitted that these steps would be the bare

minimum one might expect a prescriber to undertake in a face-to-face consultation and it is unlikely that a face-to-face consultation would take less than one minute in any circumstance, but particularly not where the medicines requested were high-risk or medicines requiring ongoing monitoring and where the prescriber had no patient history. Ms AM gave examples taken from the spreadsheet where the Registrant took 1.4 minutes, or 2.4 minutes on average to deal with each prescription.

144. This allegation was initially denied in its entirety by the Registrant, who said that he was a "*seasoned practitioner*" who could work quickly, and that the more familiar he became with the processes, the more he mastered them and the more streamlined those processes and tasks became. During his oral evidence he maintained that he thought two or three minutes per prescription was sufficient. However, having been cross-examined he then admitted this allegation.

145. The Committee noted the very high number of prescriptions the Registrant was dealing with, and considered that even if he was experienced, he could not possibly have taken all the steps required of him to clinically evaluate the suitability of the medicine requested within one or two minutes. It has already found that it is unlikely he checked the previous orders or provided appropriate safety-netting advice on every occasion.

Particulars 5 - admitted

5. In relation to 1 above, you prescribed all or some of the medicines in Schedule B to patients in approximately the quantities outlined in the schedule on the basis of an online questionnaire, when they are unsuitable to be prescribed on that basis.

146. In her witness statement, Ms AM provided a summary of each drug in Schedule B. She said that they are considered to be unsuitable for dispensing on the basis of an online questionnaire because the medicine requires ongoing monitoring or is liable to abuse. The Council's April 2019 Guidance set out categories of medication which are not suitable to be prescribed or supplied at a distance unless further safeguards have been put in place to make sure that they are clinically appropriate. These included medicines liable to abuse, overuse or misuse, or when ongoing monitoring is important. The guidance stated:

"*In light of the very real patient safety risks, pharmacist prescribers must not make prescribing decisions for high-risk medicines based mainly on online questionnaires with no access to the person's medical history or consent to contact the person's regular prescriber."*

147. Dr GC was also of the opinion that the medication set out in Schedule B is not suitable to be prescribed based solely on an online questionnaire. She stated that:

"*In order for a prescription to be authorised and for it to be in the patient's best interests (of any kind but particularly High Risk Medications) or even non-therapeutic options to be offered, a Clinician must have a full clinical picture before it is safe to prescribe. This, in my opinion, will include access to medical records or discussion with the patient's GP, corroboration of symptoms and diagnoses given, via face to face assessment, and provision of adequate monitoring and follow up."*

148. In her report Dr GC explained why patients taking the medication set out in Schedule B need ongoing monitoring. For example:

"*patients on Amitriptyline need to be monitored for side effects, efficacy, dependence and potential abuse. Patients may require liver function tests to exclude impairment."*

149. The Registrant initially denied this allegation, but then admitted it in full prior to closing submissions on facts. Having been cross-examined, he accepted that amitriptyline was not suitable to be prescribed via an online platform with no access to patients' medical records and no face-to-face consultation.

150. The Committee accepted the opinion of Dr GC, who highlighted the risks of prescribing the medication in Schedule B solely on the basis of the questionnaire completed by the patient. There should have been other safeguards in place when prescribing high-risk medication, including access to the patient's medical history, a means of communicating with the patient's GP and the facility for ongoing monitoring when required.

Particular 6.1 &6.2 - admitted

Particulars 6.3, 6.4, & 6.5 - proved

6. In relation to 1 above, on 14 October 2021, you prescribed Amitriptyline to Patient 1. In doing so, you:

6.1. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

6.2. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

6.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

6.4. failed to adequately consider the possibility of medication dependence and misuse; and/or

6.5. failed to put adequate safety-netting in place.

151. On 14 October 2021, the Registrant prescribed amitriptyline to Patient 1. Littleover Pharmacy had also dispensed a supply of amitriptyline to Patient 1 in January 2021 (issued by another prescriber). Patient 1 attempted an overdose in January 2021. The amitriptyline found with her at the time of her overdose was prescribed and dispensed by UK Meds. In her written statement, having reviewed the spreadsheet of orders Ms AM stated:

"*the Registrant approved a prescription for amitriptyline for Patient with [Patient 1] on 14 October 2021, that is on the second occasion it was prescribed. There was less than one minute between the Registrant approving this and a previous prescription for another patient The patient did not provide consent for their GP to be contacted and no GP ticket has been recorded…The medicine was dispensed by Littleover Pharmacy on 14 October 2021 and the Registrant was acting as an RP on that day.*"

152. The patient's medical record spreadsheet shows all the orders supplied or refused by UK Meds to her but does not include the clinical decision making. The questionnaires completed by patient 1

have also been produced, which state that she reported having been diagnosed with a bulging disc, back pain, fibromyalgia and migraines.

153. The Council obtained clinical advice from AOH, who confirmed in an email that:

"*The fact the patient mentioned 3 different indications and completed a number of different online consultations for different indications and different medications such as amitriptyline and carbamazepine may have been a cause for concern and maybe should have prompted the team to check her history. The patient also requested different doses on different consultation forms and on one of the amitriptyline consultations she stated she had not taken amitriptyline in the past so this would be classed as a new request for a new medication which would require more diagnostic questioning in relation to her back pain and ongoing condition to ascertain if her symptoms and condition was in fact neuropathic pain . She did however specify a dose of amitriptyline which again should have prompted the team to question her knowledge of the medication and the dose she required. Once again this should have raised suspicion with the UK meds team or would have been a natural point to intervene and contact the patient and her GP to confirm the dose.*

The patient did request quite large pack sizes of the product (56-84 tablets) which would be 56-84 days supply if she was taking 50mg once daily. The BNF states that limited quantities of tricyclic antidepressants should be prescribed at any one time because their cardiovascular and epileptogenic effects are dangerous in overdose

Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment, are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. A meta-analysis of placebo- controlled clinical trials of antidepressant drugs in adult patients with psychiatric disorders showed an increased risk of suicidal behaviour with antidepressants compared to placebo in patients less than 25 years old."

154. Dr JK was a consultant at the hospital who was responsible for Patient 1's care. He has provided a witness statement for these proceedings dated 2 August 2023, which the Registrant did not challenge. Dr JK stated:

"*I was concerned an extremely vulnerable patient, with this history of self-harm and overdose was able to access drugs so readily. I decided to go online myself and have a look at the UK Meds website and was shocked to find the criteria for prescribing medication appeared to be decided by a questionnaire completed by the patient which I considered to be open to abuse. I did not readily observe any system for third party checking and it appeared patients could fill in the questionnaire knowing what medication they wanted and adapt their responses accordingly to ensure they got the drugs of their choosing.*"

155. The Council submitted that Patient 1 was using similar information across questionnaires, and there were obviously copy and paste answers. She variously claimed to have both fibromyalgia and a bulging disc but similarly asked (on each occasion) for this medication to prevent migraines. On one questionnaire Patient 1 selected carbamazepine, but in her answers stated that she "*would like amitriptyline to prevent the migraines*". Even after this supply was refused by another prescriber, the Registrant issued a prescription of 56 tablets of Amitriptyline 50mg on 14 October 2021, when the patient submitted identical information as per the refused supply, but she selected amitriptyline instead of carbamazepine. On the 14 October 2021 questionnaire Patient 1 stated that she was also using another email address to order medication from UK Meds, which should have been an additional red flag.

156. Mrs SJ raised the issue of Patient 1 with the Registrant during the inspection, who stated that:

"*…he would be contacting UK Meds to ask them how this has happened. He then told me that was not a prescribing or dispensing error.*"

157. Having given oral evidence the Registrant admitted that he prescribed the medication to Patient 1 on 14 October 2021, that he failed to obtain adequate information in relation to the patient's health in advance of prescribing and failed to access and/or attempt to access the patient's GP

medical records. However, he continued to deny the alleged failings specified in Particulars 6.3-6.5 (lack of face-to face consultation, failure to consider the possibility of misuse/dependency and failure to safety-net.)

158. In his written reflection of October 2024 the Registrant stated "*Having worked in many primary care settings and incorporating my extensive prescribing experience I would never have allowed this patient to have obtained amitriptyline – I am knowledgeable and experienced enough to know that I would NOT in any circumstance risk prescribing this medicine to a high-risk user if I have been alerted to such information."*

159. Dr GC specifically highlights in her report the risks around amitriptyline. She stated:

"*Amitriptyline is, in my own experience and as advised by the BNF, rarely now used for depression due to the high risk of fatality in overdose and the introduction of newer, safer antidepressants, ("overdose with amitriptyline is associated with a relatively high rate of fatality"). It can be used for neuropathic pain in lower doses, but has unwanted side effects and is a medication commonly misused. In my opinion, a Prescriber would need to be confident that the patient had no addiction or mental health history and was on no other prescribed medication, such as other antidepressants, Gabapentinoids or Methadone due to the risk of unintentional overdose and cardiac issues.*

In my opinion and experience, patients on Amitriptyline need to be monitored for side effects, efficacy, dependence and potential abuse…

The short term risks of prescribing Amitriptyline from an online questionnaire are inappropriate and potentially fatal prescribing to someone with underlying alcohol or drug abuse or mental health issues. There is also the risk of confusion, drowsiness or cardiac issues. In my opinion, it is not safe to prescribe Amitriptyline without a full clinical picture.

The long term risks of prescribing Amitriptyline from an online questionnaire are withdrawal effects, risk of overdose and cardiac effects. It is not suitable to be prescribed from an online questionnaire."

160. For the reasons specified by Dr GC, the Committee considered that it was inappropriate and unsafe to prescribe amitriptyline purely on the basis of the online questionnaire completed by the patient. It is concerning that when Mrs SJ raised this with the Registrant, despite his "shock" at what had happened, he told her that he did not consider this to be a prescribing error. The Registrant said that he had access to the previous orders from UK Meds. He was relying on Patient 1 being truthful on her questionnaire (the patient gave false information on the consultation forms as she stated she had no history of mental health issues or suicidal thoughts.) Her medical records would have confirmed that she had a history of overdoses. Even looking at the questionnaire alone, there were sufficient red flags for the Registrant to have paused, and requested further information (e.g multiple diagnoses and multiple email addresses). The Committee considers that the lack of appropriate safeguards meant that the patient was able to obtain the medication repeatedly (although the Committee does accept that the Registrant provided Patient 1 with a lower dose than she originally requested), without any ongoing monitoring, when she had previously been refused it by another prescriber and when she was at a real risk of overdosing.

161. There is also no documentary evidence that the Registrant appropriately safety-netted Patient 1 on 14 October 2021.

162. The Committee therefore finds Particular 6 proved in its entirety.

Particulars 7.1 & 7.2 - admitted

Particulars 7.3, 7.4 & 7.5 - proved

7. In relation to 1 above, on 1 November 2021 you prescribed Amitriptyline to Patient 57 based on an online questionnaire in which the patient informed that his diagnosis was "can use". In doing so, you:

7.1. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

7.2. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

7.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

7.4. failed to adequately consider the possibility of medication dependence and misuse; and/or

7.5. failed to put adequate safety-netting in place.

163. On 1 November 2021, the Registrant prescribed amitriptyline to Patient 57. In the questionnaire the patient stated that the diagnosis given by his GP was "*can use*". The Council submits that plainly this is not a diagnosis of a condition and should have flagged to the Registrant that much more investigation was required prior to the prescription of this medication. On 25 February 2022 a concern was submitted by a pharmacist working at the Pharmacy in respect of this supply of amitriptyline (it is not known who this was). The pharmacist raised concerns that the Registrant was "*prescribing inappropriately and dangerously."* and that this was an ongoing issue.

164. From the order spreadsheet Ms AM noted that there was less than one minute between the Registrant approving this and a previous prescription for another patient. The patient did not provide consent for the GP to be contacted and there was no record of GP contact. The Council submits that there would not have been sufficient time in this period for the prescription to have been appropriately reviewed and the necessary checks carried out. There is no evidence of any attempts to contact the patient to discuss the questionnaire and no attempt to counsel the patient about the medicines.

165. Ms AOH also provided clinical advice about this prescription, stating:

"*The questionnaire completed had a number of highlighted concerns such as the patient stated that the diagnosis from her GP was "can use" and the dose was specified as "once a day". The patient stated that he/she had taken amitriptyline in the past so it would have been useful for the pharmacy team to have contacted the patient to confirm the dose and strength of amitriptyline and the clinical indication for the treatment such as depression or neuropathic pain. The lack of clarity in relation to the dose and clinical indication should have prompted the team to question her knowledge of the medication and the dose she required. Once again this should have raised*

suspicion with the UK meds team or would have been a natural point to intervene and contact the patient and her GP to confirm the dose."

166. The Registrant admitted that he prescribed this medication, failed to obtain adequate information in relation to the patient's health in advance of prescribing and failed to access and/or attempt to access the patient's GP medical records. However, he continued to deny the alleged failings specified in Particulars 7.3-7.5 (lack of face-to face consultation, failure to consider the possibility of misuse/dependency and failure to safety-net.) In his oral evidence the Registrant was taken to the questionnaire for patient 57, which had the words "*can use"* under diagnosis, and said that the diagnosis section was always coloured green. He thought that the 8-12 questions which had been drafted on the questionnaire by doctors were very good. He could see any previous medication which UK Meds had supplied to a patient, but no information about medication supplied by anyone else (i.e. a GP or other online prescribing service). The Registrant said that he is still baffled as to how it was that this patient was prescribed the amitriptyline based on the questionnaire. The Registrant cannot remember this prescription. He recalled that there would often be server errors on UK Meds platform and he wondered whether this could be an explanation. He is confident that he did not approve this prescription, and believes that the only logical explanation is that it was approved by the computer due to "*an IT glitch".* The Committee did not find this explanation plausible, noting that there was another prescription issued around a minute earlier, which the Registrant does not dispute he approved. It is more likely that due to the very quick rate at which he was speeding through these prescription requests, he simply overlooked the red flags in the questionnaire, including not spotting the words "*can use"* in the diagnosis box.

167. The Committee is of the view that it was entirely inappropriate and unsafe to prescribe this medication on the basis of the patient's statement that his diagnosis from his GP was "*can use".* This was irresponsible prescribing which put the patient at risk of harm.

168. There is also no documentary evidence that the Registrant appropriately safety-netted Patient 57 on 1 November 2021.

169. The Committee therefore finds Particular 7 proved in its entirety.

Particular 8 - admitted

8. Between approximately 21 September 2021 and 18 March 2022, you worked as Superintendent Pharmacist and Responsible Pharmacist of Littleover Pharmacy, Derby dispensing and/or overseeing the dispensing of approximately 54,770 prescriptions for UK Meds.

170. The Registrant admitted this factual particular.

Particulars 9, 10.1, 10.2 & 10.4- proved

Particular 10.3- admitted

9. In relation to 8, in September 2021 you entered into a business arrangement to prescribe and/or dispense medicines for UK Meds when you knew or ought to have known that they would not be subject to regulatory oversight by the GPhC or any other UK regulator.

10. You entered into the business arrangement in paragraph 9, without carrying out due diligence including assuring yourself that in relation to UK Meds:

10.1. that they were registered with an appropriate regulator;

10.2. that they were meeting the appropriate UK regulatory standards;

10.3. that their website was compliant with appropriate GPhC guidance; and/or

10.4. that the prescribing model that was used adequately safeguarded patients.

171. Although the contract between the Registrant and UK Meds was signed by the Registrant on October 16 2021 (an in fact he signed on behalf of UK Meds as well in error), the spreadsheet shows the Registrant began dispensing medicines for UK Meds on 8 September 2021 and had been prescribing medicines for them from 21 September 2021. The Committee has already found Particular 1 proved by way of admission.

172. Ms AM's written evidence, which was not challenged by the Registrant, confirmed that following conditions being imposed, UK Meds de-registered from the Council on 7 September 2021 and started operating as an online prescribing service, which was not subject to the regulatory

oversight. It engaged self-employed PIPs, including the Registrant. Around that time, UK Meds also started using the Littleover Pharmacy for the dispensing of medicines. UK Meds was no longer registered with the Council as of 7 September 2021. Ms AM stated that the inspection reports, improvement notices and notices of conditions issued to UK Meds would have been available for the Registrant to see via the Council's website.

173. The Council's 2019 guidance advises what risk assessments should be undertaken before pharmacists start working with prescribers online. It states that;

"*We expect you to make sure you do not work with online providers who are trying to circumvent the regulatory oversight put in place within the UK to ensure patient safety throughout the healthcare system.*

Working with prescribers who are not appropriately registered with the relevant UK professional regulator, and with prescribing services not based in the UK, could create significant extra risks for patients and the public. If your service lawfully involves working with prescribers or prescribing services operating outside the UK, you should make sure that:

- *you successfully manage the extra risks that this may create*
- *you have sufficient indemnity insurance in place to cover:*
    - *your service that uses prescribers or prescribing services based outside the UK, and*
    - *pharmacy staff supplying medicines against prescriptions issued by these prescribers or prescribing services*
- *the prescriber is registered in their home country where the prescription is issued and can lawfully issue prescriptions online to people in the UK*
- *the prescriber is working within national prescribing guidelines for the UK*

174. The Council submits that had the Registrant performed such a risk assessment (which he should have undertaken in his role as SI), the issues regarding UK Meds would have been apparent to him. It is further submitted that this should have prompted concerns for him before entering an agreement with UK Meds as it was contrary to the Council's guidance.

175. Particular 9 and the majority of Particular 10 were denied by the Registrant, who submitted that he performed due diligence checks to satisfy himself that "*it was a legitimate company".*

176. The Council's arguments for Particular 10 are the same as for the prescribing service at Particular 2- that the Registrant should have carried out checks on UK Meds when/after the Pharmacy started dispensing in September 2021. The Committee notes that the Registrant started dispensing the day after UK Meds deregistered and its name was removed manually from the website (which happened at 12.45pm on 7 September 2021. The Committee also noted that according to an inspector at the Council, he went onto UK Meds website on 7 September 2021 and noted that it now described itself as "*private healthcare provider, offering comprehensive medical services. It does not describe itself as a pharmacy but does state that medicines are dispensed by registered UK pharmacies."*

177. The Registrant's evidence is that he did one check only on 30 August 2021, at which stage UK Meds was still on the Council's website as a registered pharmacy. It is likely that by that stage UK Meds had already applied/agreed to be re-registered, as the process would have taken at least a few days. There is no evidence that the Registrant asked UK Meds about their registration status at the meeting on 30 August 2021. If he had, it may well be that they would have told him their plans to deregister.

178. The Committee does not consider that the check on 30 August 2021 was sufficient, particularly in light of the red flags already in existence regarding UK Meds' inspection history at that stage. The Registrant had an ongoing duty to ensure that the company was subject to regulatory oversight. He knew that it had failed inspections and had had conditions placed on it. If the Registrant had continued to carry out due diligence beyond his initial checks on 30 August 2021, (not least to check whether any additional conditions had been placed on the pharmacy), he would have discovered that UK Meds was no longer registered with an appropriate regulator as at 8 September 2021, the date he started dispensing, and would not be subject to regulatory oversight by the Council or any other UK regulator.

179. The Committee therefore finds Particular 9 of the Allegation proved.

180. In relation to Particular 10, the Registrant ultimately admitted Particular 10.3 - that UK Meds' website was not compliant with appropriate Council guidance (as the questionnaire was treatment led as opposed to condition led).

181. In relation to the other sub-particulars, the Committee considers that the due diligence which the Registrant undertook was inadequate. It all appeared to be very rushed - the idea of opening an online prescribing service was suggested to him by a patient in late August 2021 - this was not something which he had been planning or thinking about. He had one telephone call with UK Meds and then a four hour meeting. At this meeting he was provided with information that the company had in effect "failed" its inspection by the Council, where it had failed to meet multiple standards which put patients at risk of harm. He took the inspection report away with him, and checked the Council website, although only noted one Notice of Conditions, whereas in fact there were two inspection reports, Condition Notices prohibiting the supply of controlled drugs, opiates, z-drugs and amitriptyline and one Improvement Notice. The limited steps taken by the Registrant on 30 August 2021 were not sufficient for the purposes of setting up a new online business for a service which he had not provided before and had no experience of. He accepted that he did not prepare any type of business plan, and there is no evidence before this Committee that he carried out a risk assessment identifying the risks associated with prescribing and supplying high-risk medicines via UK Meds. Although the Registrant was adamant in his oral evidence that his lawyers had sent to the Council a risk assessment from September 2021, which included the risk of prescribing without access to patients' GP records, he was unable to produce it. When the Council produced the risk assessment from the Interim Order bundle, which stated "reviewed September 2021" it was exactly the same as the March 2022 risk assessment, with no mention of the lack of GP notes risk. The Committee does not find it plausible that following the inspection on 2 March 2022 the Registrant would have amended the assessment to delete this risk - it is more likely that there was no risk assessment in September 2021, or if there was one, it did not include all the relevant risks of prescribing online, including no face-to-face consultation, prescribing from a questionnaire alone and no access to GP records. For these reasons, the Registrant did not carry out due diligence.

182. The Committee therefore finds the entirety of Particular 10 proved.

Particulars 11.1, 11.2, 11.3 - admitted

Particulars 11.4, 11.5 & 11.6 - proved

11. In relation to 8 above, in your capacity as Responsible Pharmacist and/or Superintendent Pharmacist, you dispensed and/or oversaw the dispensing of high-risk medicines in circumstances where you had not assured yourself that they had been prescribed in accordance with the relevant guidance from the GMC, the RPS and the GPhC, in that they were routinely prescribed in circumstances where the prescriber had:

11.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing;

11.2. failed to access and/or attempt to access patients' GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

11.3. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

11.4. failed to adequately consider the possibility of medication dependence and misuse;

11.5. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

11.6. failed to put adequate safety-netting in place.

183. The Council submits that as with his prescribing for UK Meds, the Registrant also had the overarching obligation as the SI/RP to ensure that any UK Meds prescriptions dispensed by Littleover Pharmacy were safe and appropriate. It is the Council's case that despite these prescriptions having been approved by other PIPs, it remained the Registrant's responsibility to ensure that these were dispensed safely in accordance with the various guidance issued by the Council, the RPS and the GMC. As the prescriptions were dispensed on the basis of online questionnaires without any access to medical histories or consultations, it is contended that these prescriptions were not dispensed appropriately and in line with the available guidance. In particular, the Council's 2019 guidance states that:

"We expect you to be able to show how you are assured that all prescribers, whether medical or non-medical, follow the relevant remote consultation, assessment and prescribing guidance."

184. This particular allegation relates only to high-risk medicines dispensed by Littleover Pharmacy. The spreadsheet shows that 5,699 high-risk medicines were dispensed by the pharmacy between 7 September 2021 and 11 March 2022, and 2,922 of those high-risk medicines were prescribed by pharmacists other than the Registrant. The data provided by UK Meds does not support that any of those patients' GPs were contacted about the supply of their medication.

185. During the course of the Registrant's oral evidence, at the start of day four whilst still being cross-examined, he indicated that he had reflected overnight, and now admitted Particulars 11.1 and 11.2 He accepted that there were different and additional risks associated with dispensing online prescriptions, and extra safeguards should have been put in place, such as accessing patients' GP records or summary care records. After he had been released from his oath, just prior to closing submissions on facts, Mr Summerfield indicated that the Registrant also admitted Particular 11.3, accepting that patients such as Patient 1 and Patient 57 should have been referred to the GP for a face-to-face appointment.

186. The Registrant denied Particulars 11.4-11.6.

187. In relation to Particular 11.4 (failing to adequately consider the possibility of medication dependence and misuse) the Registrant contended that he did this, and in many cases decided to refuse the prescription request. In relation to Particular 11.5. (failing to refer patients back to their GP for appropriate assessment and/or review and/or monitoring), the Registrant relied on the fact that he did sometimes tell patients to contact their GP when he refused their medication.

188. The Committee has already commented on examples where the Registrant was routinely prescribing amitriptyline without the necessary safeguards in place, and at speed. He was also ultimately responsible for the dispensing of these medicines as the SI/RP of the Pharmacy. The

dispensers had access to very little information - they did not have access to the patient's questionnaire.

189. In relation to safety-netting (Particular 11.6) the Registrant maintained that he included safety-netting advice in every email to the patient, whether he approved or refused the prescription request. The safety-netting report he had produced had various styles of text in the box which the patient was sent. It was not clear to the Committee which orders were processed by the Registrant, as opposed to other prescribers. Some of the text boxes had lots of text, including the web addresses for safety advice. Some simply had the website address and nothing else. Many were very short, just a few words, with no hyperlinks or web addresses. There is no evidence that the patients were appropriately safety-netted in each case.

190. For all of these reasons, the Committee therefore finds Particular 11 proved in its entirety.

Particulars 12.1, 12.2 & 12.3 - admitted

Particular 12.4 - proved

12. In relation to 8 above, you dispensed and/or oversaw the dispensing of prescriptions in circumstances where the UK Meds prescribing model or service was incapable of supporting safe prescribing decision in that:

12.1. no face-to-face or other virtual consultation took place other than the use of an online questionnaire;

12.2. patients were allowed to pre-select the medicine they desired;

12.3. patients provided information primarily through a questionnaire; and/or

12.4. the service was not subject to appropriate regulatory oversight.

191. The conduct alleged in this particular relates to the Registrant's role as an SI/RP (as opposed to a PIP). The Council states that the Registrant failed to take appropriate steps to ensure that he/Littleover Pharmacy were dispensing prescriptions safely as he was working with UK Meds when it was operating outside of any regulatory agency (such as the Council), and medications were being prescribed solely on the basis of an online questionnaire.

192. The Registrant originally denied this particular of Allegation. During his oral evidence he admitted 12.1. At the closing submissions on facts stage he additionally admitted Particulars 12.2 and 12.3 He continued to formally deny Particular 12.4 on the basis that he was not aware that UK Meds had deregistered from the Council until Ms SJ informed him on 2 March 2022, although at one stage during his cross-examination he also accepted this allegation.

193. The Committee finds Particular 12.4 proved for the same reasons as 3.4 (i.e. he had an ongoing duty to ensure the UK Meds had appropriate regulatory oversight.)

194. The Committee therefore finds Particular 12 proved in its entirety.

Particular 13.1 - admitted

Particulars 13.2, 13.3 & 13.4 - proved

13. In relation to 8 above you dispensed/oversaw the dispensing of medicines in circumstances where you:

13.1. failed to have in place and/or carry out sufficient risk assessments to safely manage the risks of supplying medicines online;

13.2. failed to carry out sufficient audits to assure yourself that the service was operating safely;

13.3. failed to have in place standard operating procedures or internal policies to manage the risks associated with supplying medicines online;

13.4. failed to have in place an adequate agreement setting out how GPhC standards would be maintained;

195. This particular relates to the Registrant's obligations as SI/RP to have in place sufficient risk assessments, carry out audits, and create SOPs. The Council states that the evidence shows that 5,699 high-risk prescriptions, some with multiple items, were dispensed by Littleover Pharmacy.

196. The Council relies on the 2019 guidance which sets out advice such as undertaking risk assessments and ensuring that any online prescribing services the pharmacist engages with have safeguards in place in order for the safe supply of certain categories of medicines. The guidance gives detailed steps on safeguards to be put in place if certain medicines (including medicines liable to misuse or abuse) are to be supplied online.

197. Mrs SJ stated that the pharmacy team did not have access to the patient questionnaires or knowledge as to whether consent had been given to contact a GP to inform them of a supply. She said that this meant that the Registrant did not ensure that the Pharmacy was managing medicines safely, as the Pharmacy could not provide assurance that the GP had been informed of the supply. Mrs SJ also referred to the guidance which stated that for medicines liable to abuse, overuse or misuse, or where there is a risk of addiction and ongoing monitoring is important, the Pharmacy should have assured itself that the prescriber had been contacted in advance of the supply being made and that the GP had confirmed the prescription was appropriate for the patient. Ms SJ said that this could not be demonstrated during the inspection. The Registrant told her on the day of the inspection that all these additional checks were done by UK Meds or a prescriber before the prescription was received by the Pharmacy. However, the Pharmacy had no access to patients' records held by UK Meds to confirm this. Mrs SJ believed that the service provided by the Pharmacy was "*simply a fulfilment service*" with the pharmacist doing a basic clinical check of the prescription, limited to whether the dose and strength of the medication prescribed was suitable for the age and sex of the patient.

198. In terms of risk assessments, Mrs SJ said that although the Pharmacy had risk assessments for other pharmacy services, these did not cover the work that they did with UK Meds. Further, she said that no audits had been carried out, the roles and responsibilities for the service were unclear and were not specified in the SOPs or the Registrant's contract with UK Meds.

199. Mrs SJ was concerned that the Pharmacy could not provide assurance that the patient's usual GP had been informed that a supply had been made, or that people requesting medication for long term conditions were receiving ongoing monitoring.

200. The Registrant originally denied this entire particular of Allegation. However, just prior to closing submissions on facts he admitted 13.1. He said that there was reference to the issue of access to patients' records in the initial risk assessment from September 2021 but he was unable to provide a copy. He said that the original risk assessment had been sent to the Council by his lawyer in 2022 in the Interim Order hearing bundle. Mr Corrie was able to obtain a copy of this. The text was exactly the same as the risk assessment dated 2022, - the only difference was that at the bottom it said "*Reviewed by Shahid Hussain September 2021, March 2022, & further enhanced April 2022"*.

201. The Registrant maintained that his system of refusal/referral was sufficient for an adequate system of considering the possibility of medication dependence and misuse. He said that this minimised any potential risk. He cannot recall whether this risk was on the original risk assessment from 2021. He accepted that the risks of misuse or overdose were not mentioned on the later risk assessment of March 2022.

202. The Committee finds that the Registrant failed to carry out a proper risk assessment prior to starting the dispensing service. The Committee has already found that even if there was a risk assessment in September 2021 it is unlikely it contained the relevant risks. The Committee agreed with Mr Corrie that the only risk assessment which has been produced was *"woefully inadequate".*

203. The Registrant maintained that there was no need to carry out an audit on the online prescribing service or the UK Meds dispensing service prior to March 2022, as the business had not been up and running for six months by then. He therefore continued to deny Particular 13.2. During cross-examination the Registrant accepted that as SI he had a duty to ensure that overall the dispensing service was safe and effective, and as the RP he had a duty on the day to ensure that the medication which was dispensed was safe and effective. He was taken through the various guidance (April 2019) and agreed that proper governance includes assessing the service before it started, and then periodically reviewing it. He maintained it was appropriate to audit the service after it had been operating between 6-12 months, stating that before this point there would be insufficient data. That had always been his practice in the NHS - he would only do an audit before this point if there had been a specific incident. He could not explain why the issue of audits (or reference to lack of

access to GP records, or dealing with medicines open to misuse/abuse) were not mentioned in the risk assessment in March 2022.

204. As far as audits are concerned, the Committee did not accept that it was reasonable or necessary to wait until the service had been up and running for 6-12 months before it carried out an audit. Again, this is another example which tends to suggest that the Registrant rushed into this business endeavour without sufficient preparation and planning. He had not identified the risks that were involved, and had no system in place for re-assessing any risks (which may have been picked up by auditing). He was spending most of his time dealing with vast quantities of prescription requests, and did not take the time to take a step back and consider his duties as the RP and SI of the Pharmacy.

205. The Registrant also denied Particular 13.3, as he was of the opinion that the SOPs were adequate, albeit that they had UK Meds' name on them. He said that they were sufficiently tailored to Littleover Pharmacy. He said all staff had read them and signed to confirm this, although he did not produce a copy of this signature sheet.

206. Ms SJ's evidence was that it was acceptable for a SOP to be drafted by someone outside of the company, as long as the risks were relevant to the Pharmacy, and the Committee agrees with this. However, in this case the first set of SOPs which the Registrant produced on the day of the inspection made no mention of Littleover Pharmacy but had been drafted by the SI of UK Meds in October 2020, almost a year before Littleover Pharmacy got involved. The SOPs were due to be reviewed in October 2021 but there is no evidence that they had been. There is also no evidence that any of the Pharmacy's staff read and signed them; if the Registrant had evidence of a signature sheet, and is still the owner and SI of the business, it is surprising that he did not produce it.

207. The second set of SOPs which was provided to Ms SJ on 4 March 2022 may have been more relevant as they stated that they were for partner pharmacies. However, these did not even have a name of the author, and there is no evidence that the Pharmacy staff had read or signed them.

208. For both sets of SOPs, there was no mention of Littleover Pharmacy, but many references to the procedures relevant to UK Meds staff. For example, in the second set of SOPs there was one for Signposting which stated "*If a patient contacts UK Meds by phone, email or post, listen carefully to what they are saying to you".* Of course the Pharmacy staff had no access to the patient via phone, email or post other than emailing the prescription to them. There was no interaction between the dispensing team and the patient. This SOP was therefore not relevant to the Pharmacy's operation.

209. In light of this, the Committee considered that Particular 13.3 was proved, in that there were no adequate SOPs in place.

210. The Registrant denied Particular 13.4 as he said that it was not his responsibility to ensure that UK Meds was maintaining the Council's standards. That is not what this particular alleges, but rather that he did not ensure that the Pharmacy had an adequate agreement in place with UK Meds setting out how the Council's standards would be maintained. The Committee considers that the SLA was not adequate as it did not set out the roles and responsibilities of each party, such as what would happen if there was a dispensing error, or which party was responsible for informing the GP about the prescription. In light of this, the Committee considered that Particular 13.4 was proved.

211. The Committee therefore finds Particular 13 proved in its entirety.

Particular 14 - proved

14. Your approach to prescribing and/or dispensing in all or some of the allegations 1 to 7 and 10 to 13 was transactional in that you were processing patient requests, that had been prescribed either by yourself or others, by reference to a patient completed an online questionnaire rather than in accordance with UK prescribing guidance.

212. The Council states that its analysis shows the speed at which these prescriptions were being approved and/or dispensed and the volume of dispensed prescriptions over the five-month period. Ms AM stated that the Registrant was often issuing high volumes of prescriptions while also undertaking his role as RP at the Pharmacy. By way of example, on 29,886 occasions, the Registrant approved prescriptions in less than one minute following the previous prescription.

213. It is the Council's case that the Registrant would not have been capable of adequately reviewing the prescriptions within the times that the prescriptions were shown to have been approved, and on at least two occasions (particulars 6 and 7), this could have led to actual patient harm.

214. Mr Corrie submitted that in light of multiple failures by the Registrant, including failing to take into account the guidance, failing to carry out appropriate due diligence and risk assessments into UK Meds, and his high prescribing speed, his behaviour can only be assessed as transactional.

215. The Registrant denied this particular. He said that he was a *"seasoned practitioner"* who was able to work at speed due to his skills and experience.

216. The Committee did not accept the Registrant's contention that he could properly carry out all of the steps required in the course of processing a prescription within a period of around one or two minutes. It would not be possible to undertake the necessary checks and issue the prescription in such a short time frame. The Registrant's behaviour was "transactional" in that he was prescribing on the basis of a questionnaire where it was the patient who was specifying the medication (treatment led) as opposed to a proper consultation where the prescriber would consider the symptoms and history in order to decide the appropriate treatment (condition led). A condition led consultation is likely to have taken a lot longer than one to two minutes.

217. The evidence before this Committee includes examples where the Registrant has missed things, like previous medication orders, conflicting accounts of diagnoses or inappropriate reasons stated under diagnosis (such as "*can use".)* It is likely that this was, in part at least, due to the speed at which the Registrant was processing the prescription requests, without taking time to properly consider them. He only rejected around 3% of prescriptions requests. The Committee therefore finds that the prescribing was transactional.

218. The Committee did not consider that there was sufficient evidence provided by the Council to show that the dispensing was transactional. The Registrant had five full time dispensers. Mr Summerfield said that the evidence shows that the dispensers were dispensing roughly 71 items

per hour, for both the NHS and UK Meds dispensing. On the basis that there were five full time dispensers, this means that each dispenser was processing 14 items per hour. There were a similar number of NHS and UK Meds prescriptions, so on average each dispenser was dispensing seven UK Meds items per hour, which the Committee felt was reasonable. The Committee therefore did not find this particular proved in relation to the dispensing service.

219. However, as the allegation is drafted in the alternative (i.e prescribing service and/or the dispensing service), and as the Committee has found that the prescribing service was transactional, the Committee therefore finds Particular 14 proved.

Particular 15 - not proved

15. Your approach to dispensing identified in all or some of the allegations 8 to 13 lacked integrity in that you placed financial gain over and above the interests of patients.

220. The Committee noted that the Council has only alleged lack of integrity in respect of the dispensing service which was overseen by the Registrant, and it has found that this was not transactional. The Council has not alleged lack of integrity in respect of the prescribing service.

221. The Council submits that in relation to the approved transactions, the Registrant would have been paid £1.50 per item dispensed for the 54,770 prescriptions. This amounts to £82,155 over a six-month period. It is submitted that the Registrant's lack of integrity is supported by the high volume of dispensing and the insufficient audit procedures, risk analysis and SOPs in place to appropriately manage the risk in dispensing medications. Additionally, Mr Corrie said that the Registrant was working with UK Meds when they were not regulated by an appropriate regulatory body, and failed to carry out any due diligence into the company. Had he done so he would have been aware of the improvement notices and the conditions on their own prescribing and dispensing. The Council's case is that the only reason for the Registrant operating with UK Meds in this unsafe manner was to gain financially.

222. The Registrant denied this particular and said that he felt very strongly about the allegation of lack of integrity. He said that he had always been open, transparent and trustworthy.

223. The Registrant said that at the time of the allegation his business was financially healthy. (REDACTED). He accepted Ms AM's calculation that he had made £82,155 from the dispensing service for UK Meds. He said that the profit margin on this was around 14%-16%, so in total he made a profit of about £11,500 from the dispensing. He denied that he ever "cut corners" and said that he was not motivated by profit. He said he started the service during the pandemic in order to help patients. His profit from the previous year (up to October 2021) was around 11%-12% of the company's turnover of £1.3m, so the company was not struggling.

224. The test to be applied in cases concerning lack of integrity was set out by the Court of Appeal in *Wingate & Anor v The Solicitors Regulation Authority [2018] EWCA Civ 366*. In the judgment, SJ LJ stated that:

"In professional codes of conduct, the term "integrity" is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members…The underlying rationale is that the professions have a privileged and trusted role in society. In return they are required to live up to their own professional standards…Integrity connotes adherence to the ethical standards of one's own profession…the duty to act with integrity applies not only to what professional persons say, but also to what they do."

225. The Council accepts that the Court of Appeal made it clear that *"The duty of integrity does not require professional people to be paragons of virtue"* and the Registrant, of course, was entitled to be making a profit on the prescribing and dispensing services.

226. There is no suggestion in this case that the Registrant was being dishonest. However, while someone acting dishonestly can be said to be acting without integrity, the concept of integrity is wider than just acting dishonestly. This means that it is possible to behave without integrity but not necessarily dishonestly.

227. It appears to be accepted by both parties that the Registrant received £82,155 in relation to the items dispensed by the Pharmacy during the five-month period covered by the allegation.

228. The Committee considered that the Registrant had sufficient staff to dispense the prescriptions, and that they were being dispensed at a reasonable rate. He was making a fair level of profit, which he was entitled to do. There is no evidence that the dispensers were "cutting corners". The real focus in this case has been on the Registrant's prescribing practices, but it is not alleged that his approach to prescribing lacked integrity.

229. From the evidence before this Committee it has decided that the Council has not proved, on the balance of probabilities, that the Registrant's approach to dispensing lacked integrity.

230. The Committee therefore finds Particular 15 not proved.

IMPAIRMENT

231. Having found the majority of the facts proved, the Committee now turns to the issue of impairment by reason of misconduct. At this stage of the proceedings there is no burden or standard of proof.

232. Having handed down the decision on facts, the Registrant called four-character witnesses and gave further oral evidence himself under oath.

Ms A MP

233. Ms A is the Member of Parliament for Derby North. She has provided two letters dated 12 December 2024 and 17 December 2024. The first letter was addressed to the Registrant whom she met at "Small Business Saturday", thanking him for the services provided by his pharmacy. The second letter was addressed to the Committee, stating that Ms A has known the Registrant for a year, and that she had heard from constituents of the Registrant's efforts during the pandemic. She knew that her testimonial would be used in fitness to practise proceedings but she did not state that she was aware of the actual allegations. In her oral evidence she said that she scanned the Particulars of Allegation and recalled that they related to concerns around online prescribing.

234. In her oral evidence Ms A confirmed that she has been to the Pharmacy in Derby a few times, and has been impressed with how professional the staff are. She has found the Registrant to be engaging and professional, although she has never personally used his pharmacy services. She said that if restrictions were placed on the Pharmacy, this would have a huge impact on patients, who struggle to get GP appointments and rely on the Pharmacy's services such as the walk-in clinic.

DR B

235. Dr B is the Executive Medical Director of DHU Healthcare, who has known the Registrant on a professional basis since 2014 and has been mentoring him informally for the past 18 months. These in person mentoring meetings have taken place every four months, and Dr B said that the Registrant "*has consistently shown meticulous insight, in-depth reflection, and a firm commitment to aligning his practice with GPhC standards"* and "*has demonstrated a consistent commitment to clinical excellence through regular audits and quality reviews…His ability to uphold high standards, especially under challenging conditions such as NHS strikes and the winter respiratory illness surge, underscores his resilience and dedication to patient care.*

236. In terms of remediation, Dr B said the following:

"*Mr Hussain has shown an exceptional ability to reflect on his practice with honesty and insight. He has consistently demonstrated a willingness to examine his actions critically, recognise areas where improvements could be made, and take decisive steps to address these. This process of reflection and remediation has been central to his growth, enabling him to rebuild trust and demonstrate a genuine commitment to patient safety and clinical integrity. His compliance with GPhC interim conditions, coupled with his focused efforts on addressing the root causes of previous concerns, underscores his dedication to upholding professional standards and practising with integrity. His reflective practice has led to meaningful improvements, including enhanced documentation, greater adherence to safety protocols, and a renewed emphasis on patient-centred care."*

237. In his oral evidence Dr B said that when he was first asked by the Registrant to be his mentor the Registrant told him about the interim conditions of practice on his registration. He was also

informed about the Council's allegations, but satisfied himself that the Registrant had acted in an appropriate way and that he was skilled enough to undertake this role. At the first mentoring session he asked "*probing questions*", and thought that the Registrant had been "*a bit naive",* although he could understand why he would have trusted UK Meds in light of the fact that it was such a large company.

238. Dr B spoke about the Registrant's excellent clinical skills, and he has had no concerns regarding his practice - the Registrant worked for Dr B's company providing 111 services for many years, although this ceased in 2023 when he bought his second pharmacy. Dr B has never had any concerns about the Registrant's probity, honesty or integrity.

239. Dr B was asked about the Registrant's due diligence towards UK Meds. He said that he was never shown any paperwork regarding UK Meds, such as the Due Diligence form which the Registrant completed. He was not aware that the Registrant started dispensing for UK Meds around a week after their first meeting - he said that in the mentoring sessions they did not really concentrate on UK Meds, but looked to the Registrant's future practice. Dr B believes that the Registrant did not think through the ramifications of working for UK Meds using their prescribing model, or question their systems, but he now understands the risks. He said that the Registrant had told him that he refused one in six prescription requests, and was unaware that the number of refusals based on the Registrant's own data was closer to 3%. He also said that when things go wrong the most important thing is for the person to *"put their hands up"* and admit their wrongdoing.

Mr M

240. Mr M is a registered pharmacist and has known the Registrant for 18 months. He has been a pharmacist for approximately 40 years and in that time worked as an SI for five years. He was a locum at the pharmacy which the Registrant purchased in July 2023. He stated in his testimonial:

"*In terms of Mr Hussain clinical skills I have found them to be exemplary. He is an excellent clinician and on the occasions we have worked together I have seen first hand the level of skill he has brought*

to bear and his ability to communicate with the general public, other healthcare professionals and staff is absolutely first class."

241. In his oral evidence Mr M said that he first met the Registrant in July 2023 when the Registrant was in discussion to purchase Chase Terrace Pharmacy, where Mr M worked as a locum. After they had come to an agreement that Mr M would work for the Registrant as a locum, the Registrant then told him about the restrictions on his practice. Mr M was impressed by the Registrant's honesty and integrity.

242. Mr M evidence about the Registrant's clinical skills, and his commitment to serving the public. He spoke about his experience during the pandemic, stating that during the lockdowns GP surgeries in effect "*closed their doors*" and it was left for pharmacists to serve patients, which was very challenging. Chase Terrace Pharmacy has close links with the nearby GP practice, and they have a unique telephone number which they can call to speak to the surgery directly regarding patient queries.

243. Mr M spoke about the stress that these proceedings has had on the Registrant over the past 18 months, but despite this he has witnessed the Registrant still being professional and conducting himself in an exemplary manner. He gave evidence about the Pharmac First services which they now offer, and said that if there was any restriction placed on the Pharmacy, this would affect the public.

Mrs ZK

244. Mrs ZK, the Registrant's wife, also gave oral evidence at the impairment stage. She had provided a testimonial dated 15 November 2024. She gave evidence about the stress which these proceedings have caused her family and that they have taken over their life for the past three years. Despite this, he has continued to serve the public, and is always looking for ways to help people.

245. (REDACTED)

FURTHER EVIDENCE FROM THE REGISTRANT

246. In his written witness statement the Registrant had apologised *"to anybody who has been involved in my case*". He said that he will never be involved with a private online platform again but will continue serving his local community by providing NHS services "*with utmost professionalism, safety and competency as I have been over the past 14 years."* In his written reflection dated October 2024 the Registrant said "*it is now evident upon reflection that patient safety potentially could be compromised as patients/users may obtain medicines liable to abuse, e.g. by falsifying answers to the online questionnaire…I acknowledge and understand that completion of online questionnaires is not ideal…*

With the benefit of hindsight, I recognise that issues relating to access to medication by high risk users could have been addressed by a thorough review of each questionnaire and appreciation for the possibility of patients providing inaccurate information. However, as a pharmacist, I accept that it is my responsibility to ensure that I have taken all measures necessary to ensure any such case is managed in a proper manner".

As we move towards an increasing digital era where many services are available online, I recognise that there are some important differences between online and in-person consultations. Those differences cannot be accounted for, but significantly impact good clinical practice. Previously, I thought that online questionnaires with the safeguarding measures (i.e., ID checks, disclaimers to confirm information shared is accurate, referral tool to obtain further medical information) were sufficient, I now absolutely understand that those measures are limited by nature. I further accept that as pharmacists with independent responsibility for our actions, we cannot rely on proper working of those systems."

247. In terms of his current practice, the Registrant stated that "*I occasionally receive patient requests at my Community Pharmacy Walk in clinic for antidepressants and I confirm I have never prescribed for depression. However, these patients are appropriately referred to their GP surgeries. There is evidence of this as the GPhC inspector whilst inspecting my pharmacy in September 2023, went through every private prescription I had written over the last three years and found no concerns."*

248. The Registrant said in his written reflection that he now appreciates that the use of online platforms raises ethical concerns such as whether the information he was provided via an online questionnaire was sufficient and reliable enough to enable me to prescribe safely. In his written reflection he acknowledged many of the risks which Dr GC had highlighted in her reports. He concluded that "*On reflection, an online questionnaire does not compare to a face-to-face examination or even a video or telephone consultation. The use of verbal or non-verbal cues in video/telephone/face-to-face consultations can help to identity if a patient is being dishonest, withholding information or providing a false positive account, e.g., if a patient tells you about a symptom but on further questioning cannot explain in sufficient detail indicates a patient may be dishonest."*

249. The Registrant has also reflected on the importance of obtaining patients' records before prescribing online, stating "*This experience has enabled me to recognise that summary care records possess a valuable resource to obtain a full objective medical history along with other relevant information such as allergies, diagnoses, acute and repeat medicines record".*

250. In terms of the risk of repetition, the Registrant said in his written reflection that he "*will always ensure there is NEVER any risk of repetition with an online platform ever again, as I refuse to entertain this platform completely for the entirety of my career going forward."* He now only provides face to face consultations when prescribing.

251. With regards to remediation, the Registrant said that he immediately terminated his contract with UK Meds in March 2022 and stopped prescribing online. However, he also recognised that long-term remediation was required to address the root causes of the issues that had arisen. This involved:

- Implementing stronger clinical governance procedures to ensure that all services, including any potential future online services, are subject to rigorous oversight and monitoring. This includes regular audits, the establishment of clear protocols for face-to-face consultations, and the introduction of stricter prescription verification processes and the use of summary care records.
- Staff Training and Development - training on the ethical and legal aspects of prescribing, safeguarding vulnerable patients, and maintaining clear and accurate documentation.
- Collaboration with Medical Professionals: fostering closer working relationships with other healthcare professionals, including GPs, to ensure that any prescribing decisions are made in

collaboration with a patient's broader healthcare team. The Registrant has had several meetings with the executive medical director for NHS 111 who has provided mentorship over the last three years. He also carried out a peer review with this GP on 2 October 2024 regarding "*Amitriptyline in Community Pharmacy".*

- Ongoing Continuing Professional Development ("CPD") - completed courses on patient safety, remote consultations, safeguarding, and suicide prevention, all of which have contributed to the Registrant's understanding of the broader context in which he operates as a pharmacist.

252. The Registrant continues to be involved in the day-to-day running of Littleover Pharmacy and Chase Terrace Pharmacy where he works as RP, SI and Advanced Clinical Practitioner. He said that he has undertaken targeted CPD to gain a better and sounder understanding of the issues in this case. This included numerous CPD courses focusing on the online platform, digital changes in Pharmacy, prescribing safely and safety-netting. He has also successfully completed a "Designated Prescribing Practitioner" course to help with future prescribers. As part of its NHS work several clinical audits have been conducted and they have received 100% scores.

253. The Registrant gave further oral evidence at this stage of the proceedings for two and a half hours. He said he had read the Committee's decision on facts and respected it. He also accepted that the facts found proved amounted to serious misconduct.

254. The Registrant had provided within his bundle details of his NHS consultations with Derby Urgent Treatment Centre for the last five and half years. He took the Committee through three examples (migraine, headache and sinus congestion) to demonstrate what his usual practice is when seeing a patient face-to-face, including procedures for patient's ID, checking their medical history from the GP notes, taking observations, examination, red flags, treatment and safety-netting. Mr Summerfield took the Registrant through the RPS Competency Framework in detail, and the Registrant explained how each part of the consultation aligned with the framework guidance. He said that in the future he will never get involved with online prescribing, not even telephone or video consultations with the patient, but instead will only see patients face-to-face.

255. The Registrant also supplied copies of audits of his consultations which have been carried out by clinical leads regarding his work at the Urgent Treatment Centre. The first audit from 22 June 2022 had an overall score of 99%, and the clinical lead commented "*Shahid has demonstrated excellent*

prescribing and consultation skills…has shown no compromise in patient safety…keep up the excellent work!" A second audit dated 30 September 2022 had a 100% score.

256. The Registrant spoke about how pharmacy means everything to him, and how hard he has tried to put things right during the past three years, including written reflections, peer discussions and over 28 relevant CPD courses. He sought out a mentor as he wanted someone who could help him.

257. During cross examination the Registrant was taken to the various standards by Mr Corrie, and after some detailed consideration he finally accepted that he had breached standards 1, 2, 3, 5, 6, 8 and 9 having now reflected on his conduct. He accepted that the UK Meds model was not capable of supporting safe practice, and that he put patients at risk of harm. These risks included dependence, overdose, the wrong medication being prescribed or contraindications, and he accepted that these risks were serious and unacceptable. Although it was never his intention to put patients at risk, in hindsight he can see that this was unfamiliar territory for him and his prescribing and dispensing were not safe.

258. Mr Corrie asked the Registrant why, after three years of reflection, he only came to make admissions regarding his conduct during the course of and after the conclusion of his oral evidence. The Registrant said that it was the way Mr Corrie had explained the allegations in detail, and had gone through the spreadsheet of data that made him understand things. He denied that he only finally admitted his own culpability when he realised he had no choice, based on the evidence .

MISCONDUCT

259. In reaching its decision on impairment the Committee considered all the evidence and information before it at this stage and the previous stage of the proceedings, together with the oral submissions of Mr Corrie and Mr Summerfield.

260. The Committee considered the question of impairment in two separate stages. Firstly, it considered whether the Registrant's actions which have been found proved constitute the statutory ground of misconduct for the purposes of the fitness to practise criteria.

261. The case law is clear that not every failing amounts to misconduct: it has to be serious, the type of behaviour that other members of the profession would regard as well below the expected standards. In the case of Roylance *v GMC (No.2) [2000] 1 AC 311* by Mr Walker, Lord Clyde said that 'misconduct' was:

"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed…in the particular circumstances…And such falling short must be serious."

262. Further, in the case of *Remedy UK Ltd v General Medical Council [2010] EWHC 1245 (Admin)* it was said that:

"Misconduct is of two principal kinds. It may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outside the course of professional practice, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."

263. In this case it is the first type of misconduct that is alleged, as it involved the Registrant's exercise of professional practice.

COUNCIL'S SUBMISSIONS ON MISCONDUCT

264. It is submitted by the Council in its skeleton argument that although much of the evidence in this case relates to the poor systems in place by UK Meds, the ultimate responsibility for prescribing or dispensing a prescription lay with the Registrant. It highlighted that prescriptions for high-risk medications were being approved in a matter of minutes from the order being submitted or from review of the previous prescription, and that this was all ongoing while the Registrant was simultaneously carrying out his responsibilities as the RP at Littleover Pharmacy.

265. It is the submission of the Council that the approach taken by the Registrant was at best indifferent and at worst harmful to patients, and that he failed to recognise that regardless of the method of prescribing, the same steps, assessment and caution must apply.

266. Mr Corrie submitted that by persistently failing to undertake proper reviews of patients seeking high-risk medicines, the Registrant enabled patients who were suffering from issues with addiction to circumvent the regulations designed to safeguard patients from inappropriately obtaining medicines. He said that the Registrant had breached the following Standards for pharmacy professionals:

- Standard 1 (provide person-centred care)
- Standard 2 (work in partnership with others)
- Standard 3 (communicate effectively)
- Standard 5 (use professional judgement)
- Standard 6 (behave in a professional manner)
- Standard 8 (speak up when they have concerns or when things go wrong)
- Standard 9 (demonstrate leadership)

267. The Council submitted that the Registrant's conduct fell far short of the standards expected of a pharmacy professional and would be viewed as deplorable by fellow professionals, and accordingly, it meets the threshold for a finding of misconduct.

268. In his oral submissions Mr Corrie highlighted that the Registrant was in a position of power and responsibility and was a gatekeeper of medication. He had a duty to comply with the guidance regarding at distance supplying, and there were multiple, gross breaches of the guidance, both as a prescriber and a pharmacy owner.

REGISTRANT'S SUBMISSIONS ON MISCONDUCT

269. Mr Summerfield submitted that his client had accepted during his oral evidence at stage two that the facts which have been found proved amount to serious misconduct.

DECISION ON MISCONDUCT

270. The Committee considers that the Registrant's failings were serious and could have resulted in harm to patients. The Council's guidance had been in place for well over two years when the Registrant started working for UK Meds as a PIP. The Committee is satisfied that the 2019 guidance was sufficiently clear to provide advice to pharmacists who wished to move into the online business. It provided a checklist of areas which they should consider. The Registrant said that he thought that he could take his knowledge of community pharmacy and apply it to an online model, which was entirely inappropriate without further safeguards. He rushed into the endeavour without carrying out proper due diligence, including no or inadequate risk assessments. He knew from the start what the prescribing model would be, and chose to prescribe when there was no possibility of a face-to-face consultation with the patient, and no access to their medical records.

271. The Registrant, acting as the RP, failed to consider the risks involved in the online model which simply relied on the patient questionnaire. He should have ensured that there were procedures in place to prevent inappropriate supplies of high risk medication, including drugs which are open to misuse and abuse, to vulnerable members of the public. Medicines were routinely sent out to patients even though the Registrant did not have access to their medical records and in the majority of cases knew that they had not consented for their GP to be informed. There were no adequate systems in place to audit either the supply of medication, or when a prescription had been refused.

272. The Committee agrees with the Council that the Registrant was not following the guidelines issued by the Council for providing pharmacy services at a distance. This was essentially run as a commercial, transactional model. There were not sufficient safeguards in place. It was possible for amitriptyline to be prescribed and dispensed to patients without appropriate safety checks. The

Registrant relied on the information on the patient's questionnaire being true. The Registrant did not make sufficient checks (for example the patient had written "*can use"* in the box for the patient's diagnosis). The Council's guidance requires that the at distance prescriber should proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP). The Council's guidance states that where the supply involves medicines which are liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, steps should be taken to ensure that the prescriber has contacted the GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the prescription is appropriate for the patient and that appropriate monitoring is in place. Where there is no regular GP, or there is no consent, there must be a clear record of justification for prescribing. The Committee considers that the Registrant did not follow this guidance. Clearly there were not adequate safeguards in place. The Registrant could not be assured that he knew of the patient's full medical history (other than previous UK Meds orders), and therefore may not have had sufficient information in order to prescribe safely.

273. The Committee noted that in his written evidence the Registrant stated:

"*As I continued to work with the online platform, I became aware of the risks associated with online prescribing at the end of the five-month period where I was alerted by the GPhC. The inability to physically assess patients was a glaring limitation. Online consultations often rely on the patient's self-reporting of symptoms and medical history, which can be incomplete or inaccurate. In some cases, patients may unintentionally omit critical health details, or in rare instances, they may provide misleading information to obtain certain medication. This raised significant concerns about the potential for inappropriate prescribing, particularly with medications that have a potential for misuse. After contacting the clinical leads regarding this they suggested I refer such consultations to them for further contact. I recall as I increased my referral numbers to the clinical leads, they would contact me and bluntly state I am increasing their workload. From this moment, I called the director at UK Meds and suggested reducing the number of prescriptions sent to me to which he did not like. From this moment in December 2021, I realised there was a lack of support from the clinical leads and director and discussed with my pharmacy team to focus our attention on our NHS services with a view to terminate the private service soon. Shortly after, a reduction in the number of*

prescriptions was noted to which I felt at the time was manageable – however I could not rule out the fact that the clinical leads were reluctant for me to refer any cases to them, allowing me to feel isolated to some degree."

274. This indicated to the Committee that the Registrant was aware of the risks of the online prescribing model. UK Meds "*were not happy*" when cases were referred back to the clinical leads, and by December 2021 the Registrant did not feel supported. Nevertheless, although he spoke to the clinical leads and as a result the number of prescriptions directed his way reduced, he did not change his own prescribing practice.

275. There is no evidence that any patient came to actual harm as a result of the Registrant's own prescribing. However, there is evidence that at least one patient (Patient 1) came to serious harm as a result of UK Meds prescribing model. Clearly the lack of safeguards put patients at risk of harm, as there was the potential for them to get hold of high risk medicines when it was inappropriate. Tighter safeguards should have been put in place where there was a risk of misuse, overuse or overdose. The Registrant eventually agreed with this, but only after some probing by Mr Corrie.

276. In addition, as the SI the Registrant had a statutory duty to ensure that the business was at all times carried on in ways that ensured its safe and effective running, and he breached that duty.

277. The Committee finds that the Registrant breached the standards referred to above, and that other members of the profession and the public would take a dim view of the Registrant's conduct. Issuing prescriptions at speed without the appropriate checks and safety-netting fell well below the standards required.

278. For these reasons the Committee considers that the actions/failings of the Registrant amounted to serious misconduct.

CURRENT IMPAIRMENT

279. The Committee next proceeded to the second part of the test, which is to consider whether the Registrant's fitness to practise is currently impaired by reason of his misconduct.

280. Rule 5 provides that the Committee must have regard to the criteria specified in that Rule when deciding in the case of any registrant whether or not the requirements of fitness to practise are met.

281. Rule 5(2) provides:

> "In relation to evidence about the conduct or behaviour of the registrant which might cast doubt on whether the requirements as to fitness to practise are met in relation to the registrant, the Committee must have regard to whether or not that conduct or behaviour—
>
> *(a) presents an actual or potential risk to patients or to the public;*
>
> *(b) has brought, or might bring, the profession of pharmacy into disrepute;*
>
> *(c) has breached one of the fundamental principles of the profession of pharmacy; or*
>
> *(d) shows that the integrity of the registrant can no longer be relied upon."*

282. Although the Committee's determination must focus on the present position, that is to say whether fitness to practise is currently impaired, it is clear from leading cases such as *Cheatle v General Medical Council [2009] EWHC 645* that in order to form a view as to current impairment, it must take account of the way in which the Registrant has acted in the past, although a finding of misconduct in the past does not necessarily mean that there is impairment of fitness to practise today.

283. It was said in the case of *Cheatle:*

> "*the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The Fitness to Practise Panel thus looks forward not back. However, in order to*

form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past...this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct."

284. In the case of *Cohen v General Medical Council [2009] EWHC 581* Silber J set out the following guidance:

"*It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

285. In the case of Yeong v GMC [2009] EWHC 1923 (Admin) Sales J said:

"in looking forward the Panel is required to take account of such matters as the insight of the practitioner into the source of his misconduct, and any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required to have regard to evidence about matters that have arisen since the alleged misconduct occurred."

286. In addition, in *CHRE v (1) NMC and (2) Grant [2011] EWHC 927 (Admin*) Cox J considered the case of Cohen and stated:

"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances...When considering whether fitness to practise is currently impaired, the level of insight shown by the practitioner is central to a proper determination of that issue."

COUNCIL'S SUBMISSIONS ON IMPAIRMENT

287. The Council submitted that limbs (a) - (c) of the Rule 5 criteria above are engaged in this case, and that the Registrant's behaviour would significantly undermine public confidence in the profession and bring it into disrepute.

288. In his oral submissions Mr Corrie relied on the case of *Dr Kimmance v GMC [2016] EWHC 1808 (Admin)* where it was said that in terms of remediation and insight "*A doctor or other professional who has done wrong has to look at his or her conduct with the self-critical eye, acknowledged fault, say sorry and convince a panel that there is real reason to believe he or she has learned a lesson from the experience.".* He also referred to the case of *Sayer v GOC [2021] EWHC 370 (Admin)* where it was said that the future risk of repetition needs to be distinguished from the Registrant's remorse.

289. Mr Corrie highlighted that the Registrant made admissions very late in the day, and continued to deny some of the allegations. He acknowledged that the case law states that just because the facts have been denied, this does not automatically mean that there has to be a finding of impairment. However, in this case Mr Corrie urged the Committee to look at the Registrant's oral evidence, including that he continued to assert that his due diligence was satisfactory, he regarded his safeguards (refusals or referrals of the prescription requests) to be sufficient (even during his evidence at stage two). Mr Corrie also submitted that the Registrant's apparent motivation for

signing up with UK Meds is not entirely consistent with the speed at which he was prescribing, or the examples of poor practice (Patients 1 and 57, and the ventolin and amitriptyline patients).

290. In terms of the testimonials, Mr Corrie submitted that Ms A's evidence is probably more relevant to the next stage of the proceedings, if it is reached. He referred to Mrs ZK's evidence that her husband "*was being accused of things that weren't the case",* which, in effect, has been the Registrant's stance up until the hearing. With regards to Dr B, although Mr Corrie considered that he was an impressive witness, he questioned the extent to which he and the Registrant had actually discussed the UK Meds model and its faults. There had also been no discussion regarding the speed at which the Registrant was prescribing or a consideration of the number of prescriptions he refused. Mr Corrie submitted that Dr B's evidence was a *"double edged sword"* as it transpired that the Registrant had not given to him all of the relevant information regarding the allegations. Indeed, Dr B said that he would have expected a registrant who has done wrong to put their hands up and admit the wrongdoing straight away.

291. Mr Corrie submitted that the Registrant's partial admissions and reflections have come very late in these proceedings, and that it is highly unusual for a registrant to make admissions only after cross-examination. He said that the Registrant's insight is not yet complete, and that there remains a risk of repetition. He also submitted that there needs to be a finding of current impairment in the wider public interest.

292. If the Committee were to find no impairment, it has the option of still issuing a warning to the Registrant. Mr Corrie referred to the case of *Professional Standards Authority (PSA) v (1) General Medical Council (2) Uppal [2015] EWHC 1304 (Admin)* and in the case of *Fopma v GMC, [2018] EWHC 714 (Admin),* where Baker J dealt with the question of impairment and specifically what is meant by "the reputation of the profession". He said that "*A failure to find impairment in any given case, whilst warnings as to future conduct can still be issued, is tantamount to an indication on behalf of the profession that conduct of the kind need not have regulatory consequences. If that, depending on the nature of the conduct in question, would itself be an unacceptable conclusion, then that can in any given case be a sufficient basis in itself to justify or indeed compel a conclusion of impairment".*

293. Mr Corrie also referred to the case of *The General Medical Council v Armstrong [2021] EWHC 1658 (Admin)* which held that the categorisation of a case as 'exceptional' signifies that the nature of the issues in play are such that it will be only in an unusual or rare case that one set of factors will outweigh others. The consequences of a finding of dishonesty in the professional regulatory context on the overarching objective, mean that to justify a finding of no impairment, the factors on the other side will need to be extremely strong. Mr Corrie said that although these cases involved dishonesty, the principles contained within them are analogous to the present case.

REGISTRANT'S SUBMISSIONS ON IMPAIRMENT

294. On behalf of the Registrant, Mr Summerfield submitted that the Registrant is a fully reflective practitioner with full insight into his past and current conduct. He submitted that this has fed into and shaped the way in which the Registrant practises today. It is further submitted that with reference to the personal component, the Registrant's fitness to practise is not impaired.

295. The Registrant provided over 50 pages of supportive testimonials, including from two local MPs and three local councillors who refer to the valuable services he provides to the community. There were also multiple testimonials from many fellow pharmacists, doctors, nurses and numerous patients. Four witnesses gave oral evidence to support the Registrant.

296. Mr Summerfield relied upon the evidence of Mr M and Dr B regarding the Registrant's substantial remediation. He also said that the Registrant had reflected deeply and extensively. He relied upon the Registrant's audits and patient feedback reviews as evidence of his current practice. He said that the Registrant's misconduct has been addressed, and he has not prescribed online since March 2022, and never intends to do so again in the future. He submitted that the risk of repetition is "*close to zero"* .

297. Mr Summerfield referred to the case of *Gleeson v Social Work England [[2024] EWHC 3 (Admin),* which held that the principles in the *Sayer* case still applied. These included that insight is concerned

with future risk of repetition and to this extent, it is to be distinguished from remorse for past conduct; a denial of misconduct is not a reason to increase sanction; and it is wrong to equate maintenance of innocence with lack of insight. He also relied on the case of *Towuaghantse v General Medical Council [[2021] EWHC 681 (Admin),* where it was held that a registrant's "*deployment of a robust defence, which was his right, should not have been construed as a refusal to remediate, let alone an incapacity to remediate…the absence of any significant gap between the findings of fact and the commencement of the impairment and sanctions phases means that it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding phase then almost immediately in the impairment phase to demonstrate full remediation by fully accepting in a genuinely sincere manner everything found against him. In my opinion the capacity of the registrant to remediate sincerely should be judged by reference to evidence unconnected to his forensic stance in the fact-finding phase (unless the fact-finding decision included findings of blatant dishonesty by the registrant).*"

298. With reference to the public component, it is submitted by Mr Summerfield that a fully informed member of the public or a member of the pharmacy profession, knowing this case and having read and heard all of the evidence placed before this Committee, would be fully supportive of the Registrant in his argument that he has learned from his past conduct and has fully reformed from his time at UK Meds. It is contended that the public or the profession would consider that the Registrant's fitness practise is not currently impaired.

299. Mr Summerfield submitted that it would be appropriate to find no impairment, but issue a warning to the Registrant. He said that the cases of *Uppal, Fopma* and *Armstrong* were not relevant as there was no dishonesty in the present case. He submitted that there was "*compelling evidence"* before this Committee that the Registrant understands why he is before his regulator, understands the gravity of the misconduct and understands the impact it has had on the public and the profession.

DECISION ON CURRENT IMPAIRMENT

300. The Committee finds that Rules 5(2)(a) to (c) were engaged at the time of the misconduct.

301. The Registrant put patients at risk of harm by failing to ensure that there were proper procedures in place for the prescribing of high risk medication liable to misuse or abuse, or for the oversight of prescribing at a distance, (although there is no evidence that any patients actually suffered harm). The risk was that the medication could have been sent out to patients who had addictions and others for whom they may not have been safe or appropriate. Patient 1 had previously been refused amitriptyline by her GP, who had notified UK Meds that it was inappropriate to prescribe her this medication, yet the Registrant prescribed it to her, as he did not have access to her medical records. The Registrant did not have sufficient information from patients in order to prescribe safely, but relied on the clinical leads at UK Meds assuring him that they would deal with the appropriate safeguards before passing on the prescription request for him to issue, without any additional, separate checks or safeguards in place (such as checking the patients' medical records or liaising with their GP).

302. The Committee also finds that the Registrant brought the profession of pharmacy into disrepute, and breached a fundamental tenet of the profession, namely that Pharmacists should protect the public and put patient safety first. During cross-examination at stage two of these proceedings the Registrant accepted that he was not delivering patient-centred care, and that patients were put at a risk of serious harm as a result of his actions.

303. So Rule 5(2) was engaged at the time of the misconduct. However, the Committee also took into account that it took place nearly three and a half years ago, and there has been no repetition since (although he has not been able to prescribe online as he is subject to conditions prohibiting him from doing so). It therefore considered carefully the evidence and submissions to decide if there was current impairment.

304. Since the misconduct took place in September 2021 to March 2022, the Registrant has continued to work as the SI, RP and Advanced Clinical Practitioner at the Littleover Pharmacy and has opened another pharmacy. He continued providing urgent care to the local public at the NHS Derby Urgent Treatment Walk-in-Centre until the end of 2023 (he stopped as he bought the second pharmacy, but would like to return to this work part time in the future.) The Registrant has provided several clinical audits conducted by Clinical Leads, GPs and Advanced Clinical Practitioners of this NHS urgent care work which show impressive results. Mr M works with the Registrant regularly and has no concerns about his clinical competence. Similarly Dr B spoke very highly about the Registrant's professionalism and clinical excellence. These are views reflected in the many testimonials which the Committee has seen.

305. The Committee took into account that the Registrant's prescribing element within his Pharmacy was reviewed by the Council in September 2023 where they requested GP referral letters, Patient Medical Record ("PMR") entries and various consultation summaries. The Committee accepted the Registrant's evidence that there were no issues highlighted with his prescribing habits, and his record keeping was appropriate. Based on the evidence before it, the Committee has no concerns regarding the Registrant's current practice, which is limited to prescribing face-to-face, with full access to medical records. The Registrant came across as a committed Pharmacist who is highly regarded by many in his community.

306. The Committee noted that the Registrant has vowed never to prescribe online again. That in itself does not equate to remediation, or is enough to say that there is no risk of repetition, just because the Registrant has said he will not prescribe online in the future (he said that he would not prescribe unless there was a face-to-face consultation, so not even by telephone or video). The Committee considers that the Registrant is unlikely to repeat this particular misconduct, as these proceedings have clearly had a large effect on him. If he did decide to prescribe online in the future, the Committee considered that it would be unlikely that he would use the UK Meds prescribing model.

307. However, the Committee also considered the Registrant's level of insight in order to decide if his fitness to practise is currently impaired, and this is the area that gives the Committee some concerns. The Registrant said that he has been reflecting on his conduct in depth almost every day

for the past three years, has had numerous meetings with his mentor, had peer discussions on relevant topics, has undertaken numerous CPD activities and has written multiple reflections. Despite this, he came to this hearing denying all but one of the allegations, (and the one he did initially admit was a factual allegation only). For the first day of his oral evidence he maintained that his prescribing and oversight of the dispensing was safe. He was of the opinion that his due diligence was sufficient, his risk assessment and SOPs were adequate, and he did not need to audit his new business for six months. In addition, he thought that prescribing within a minute or two was appropriate and safe. He said that it was only when Mr Corrie explained to him the details of the allegations did he understand "*where the council was coming from".* It is to his credit that he finally admitted some of the allegations.

308. The Committee accepts that just because a registrant has denied an allegation which is found proved, this does not automatically mean that their fitness to practise is impaired. It took note of the cases referred to by Mr Summerfield (*Gleeson* and *Towuaghantse).* However, it also noted the case of *Sayer* which stated that "*attitude to the underlying allegation is properly to be taken into account when weighing up insight: Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight."*

309. The Committee is not convinced in this case that the Registrant has demonstrated full and meaningful insight into the misconduct. Even when he was giving evidence at stage two of these proceedings the Registrant found it difficult to readily accept that the proven facts amounted to misconduct and represented serious breaches of the standards, although he did eventually concede this. The Registrant's journey towards insight has been developing, but it appears that it was only during this hearing that he finally was able to admit to himself, as well as the Council, the extent of his culpability.

310. The Committee accepts that during his written reflections and his oral evidence the Registrant has displayed great remorse. He has engaged with the Council ever since the inspection in March 2022 and has undertaken relevant remediation, which included reading and reflecting on his learning, and a relevant peer discussion on amitriptyline. There are many positives about the Registrant's practice, but his insight around his online prescribing is still developing.

311. The main concern which the Committee has is in relation to the Registrant's insight as to why the misconduct occurred. For example, what were the triggers for him jumping into this business venture so quickly without carrying out due diligence? The Committee was not convinced by his explanation that his motivation was to provide patients to healthcare services, and in particular prescriptions. The Committee noted from the evidence (for example Patient 57) that it still took up to four days from the Registrant issuing the prescription and the patient receiving the medication through the post - this is the same time frame which the Registrant said was the average wait for a GP to issue a repeat prescription. The Registrant also relied on the fact that his motivation was due to the pandemic. However, the pandemic had been going on for a year and a half by the time he entered into the arrangement with UK Meds. All lockdown restrictions had been lifted in July 2021. There is no evidence that the Registrant had thought about prescribing online at any time before 22 August 2021. Even then, he did not prepare a business plan, carry out due diligence and then approach a suitable company. Dr B has given evidence that by 2021 UK Meds had been in the news, and there had been a BBC Panorama programme highlighting its unsafe practices. The Registrant also said that (REDACTED) several weeks before he met with UK Meds and this was a further motivation. The Committee did not accept that this was a reason for deciding to prescribe online; he was not saying that his illness was due to a lack of healthcare services.

312. The Committee accepts that the Registrant is very remorseful, and he is clearly highly regarded by his local community. However, it appears that he has struggled to admit to himself and others his misconduct. For example he sought out mentoring from Dr B which is commendable, but they did not look in detail at the reasons for the misconduct, instead focussing on the future. Until the Registrant has full insight as to why he acted the way he did, rushing into this venture, there remains a risk that if he were to come across another business opportunity in the future, there is a risk that he would jump straight in without carrying out the necessary due diligence and risk assessments. If this were to happen in a healthcare context, there remains a risk to patient safety.

313. In light of this the Committee has decided although the risk of repetition regarding online prescribing is not high, the Registrant does still represent a risk to patient safety. His fitness to practise is therefore currently impaired with regards to the "personal component."

314. The Committee also considered the wider public interest criteria and the comments in the *Grant* case referred to above. The Committee acknowledged that there is no evidence of actual harm to patients. However, the Registrant's misconduct was serious, and he breached multiple standards. This was not an isolated incident, but involved a substantial amount of irresponsible prescribing of high risk medication online without the appropriate safeguards in place for a period of five months.

315. The Committee has decided that a reasonable member of the public, knowing all of the circumstances of this case, would consider that there needs to be a finding of current impairment in order to mark the public interest, and the seriousness of the misconduct. The "circumstances of the case" include that the Council's guidance had been in existence for two years, the Registrant knew that he was prescribing high risk medication without access to patients' medical records or their GPs, and the speed at which he was prescribing. His due diligence of UK Meds was not sufficiently robust, and he jumped into this endeavour without paying sufficient attention to the risks to patient safety.

316. For these reasons the Committee therefore finds that the Registrant's fitness to practise is also currently impaired in order to mark the public interest.

DETERMINATION ON OUTCOME

317. Having found that the Registrant's fitness to practise is currently impaired, the Committee now moves on to sanction/outcome.

318. In reaching the decision on sanction it has considered all of the evidence referred to in the determination of facts and impairment, together with the oral submissions of Mr Corrie and Mr Summerfield. It also had in mind the Council's Fitness to Practise Hearings and Outcome Guidance (revised March 2024).

319. The sanctions available to the Committee are those set out in Article 54 of the Pharmacy Order 2010. In summary, it may decide to take no action, issue a warning, direct that the entry on the register be conditional, order that the entry on the register be suspended for a period not exceeding 12 months, or make an order that the entry in the register be removed.

320. The Committee understands that the three-fold purpose of sanction is the protection of the public, the maintenance of public confidence in the profession and the maintenance and declaration of proper standards of conduct within the profession. It is not the purpose of sanctions imposed by this Committee to punish a registrant, although such a sanction may have a punitive effect.

321. In the case of *Bolton v Law Society* [1994] 2AER 486 it was said that the reputation of the profession is more important than the fortunes of any individual member. It was observed that the Committee is entitled to give more weight to the public interest than to the consequences for any individual registrant. There is a need to demonstrate to the public, and to practitioners, the importance of adhering to the fundamental tenets of practice by declaring and upholding proper standards of professional behaviour. There is also a need to maintain public confidence in the profession and the regulatory process.

322. The Council's '*Good decision making: fitness to practise hearings and sanctions guidance'* invites the Committee to consider a number of factors, namely:

- the extent to which a registrant has breached the standards as published by the Council
- the interests of the Registrant, weighed against the public interest,
- the overarching objectives of the GPhC
- the personal circumstances of the Registrant and any mitigation he may have offered
- that the decision is sufficient to protect the public
- any testimonials or character references given in support of the Registrant,
- any relevant factors aggravating the conduct in the case,
- any statement or views provided to the Committee by a patient or anybody else affected by the conduct of the Registrants,
- submissions made by the Council's representative and by the Registrant or their representatives,

- the content of the outcomes guidance document, and
- any other guidance published by the Council

REGISTRANT'S EVIDENCE

323. The Registrant had given further evidence at stage two of the proceedings which included evidence relating to stage three if the Committee found current impairment. He highlighted that Littleover Pharmacy passed its recent inspection and the conditions prohibiting online prescribing have been removed by the Council. He spoke about his passion for pharmacy, and how it is so important to him. This was echoed by his wife's evidence, who said that he was always looking for ways that he could serve the public.

324. (REDACTED). He said that if he was prevented from practising then it would be financially very difficult, as he would have to employ an SI and a pharmacist to replace him. He has had a look online and believes that employing an SI would cost around £60,000-£70,000 per year. He currently employs 21 staff and said that their jobs would be put at risk. The pharmacies dispense 23,000 items per month. However, his main concern is that he would not be able to find another Advanced Clinical Practitioner to run his walk-in clinic, and this would put this service at risk (evidence which was echoed by Mrs A). He relies on this income to support the business.

COUNCIL'S SUBMISSIONS ON SANCTION

325. Mr Corrie referred to the Council's overarching objectives, which are set out above. He said that the Committee must undertake a balancing exercise, balancing the Registrant's own interests against the public interest, although ultimately it is entitled to place greater weight on the public interest. He highlighted that the Registrant has not provided detailed evidence or supporting documents regarding the impact a suspension would have on his business, although Mr Corrie accepted that of course it would be detrimental to the Registrant and his family.

326. Mr Corrie said that taking no action or issuing a warning would not be appropriate in this case, taking into account that the Committee has decided that there is some ongoing risk to the public. He said that they would not achieve the aims of a regulatory sanction. He submitted that whilst conditions of practice may well deal with the issues around public protection, they would not satisfy the wider public interest considerations, due to the gravity of the misconduct.

327. The Council's position is that appropriate and proportionate sanction in this case is one of suspension for 12 months. He said that, in light of the Committee's findings, the Council's position had moved, and that it was now accepted that the Registrant's behaviour is not fundamentally incompatible with continued registration, so a strike off order is not required. This is due the Committee's findings in relation to the Registrant's insight, remediation, and the testimonials provided on his behalf.

REGISTRANT'S SUBMISSIONS ON SANCTION

328. Mr Summerfield conceded that taking no action or issuing a warning would not be proportionate in light of the Committee's findings. He outlined the mitigating factors in this case, including no other regulatory concerns before or after this misconduct, full cooperation with the council, the Registrant's extensive remediation, remorse and developing insight.

329. Mr Summerfield submitted that a conditions of practice order would be the appropriate sanction, reminding the Committee that the Registrant has worked safely under conditions for the past three years. He provided the Committee with a list of proposed conditions including a mentor (suggesting Mr M), regular reports to the Council, a Personal Development Plan and a continuation of the current prohibition of online prescribing (for private prescribers). He said that this would be sufficient to satisfy the public interest as it would send out a warning to pharmacists and a message to the public that these matters are serious.

330. Mr Summerfield said that a sanction of suspension would be disproportionate, taking into account that:

- It would deprive the Registrant of his ability to practice;
- It would deprive the community of an "*exceptional clinician who is highly regarded by his peers and the public";*
- It would most likely put at risk the delivery of pharmacy services to that community through pharmacies as the Registrant is the SI of two pharmacies
- It would most likely put at risk the livelihoods and jobs of 21 other individuals who rely upon the Registrant for employment;
- It would most likely put at risk the Registrant's family, given that he contributes significantly to the household expenditure.

331. Mr Summerfield said that if the Registrant were suspended from practice, he would only be able to work on his insight in an academic way, and would not be able to show that it had been tested in a working environment. However, if the Committee did decide to suspend the Registrant, Mr Summerfield submitted that a suspension of two months would be sufficient.

DECISION ON SANCTION

332. The aggravating factors which the Committee identified were as follows:-

- The misconduct took place in the workplace, and over a period of approximately five to six months
- The case involved a substantial number of transactions (36,312 prescriptions issued, of which over 5,000 were high risk, and 54,770 prescriptions dispensed)
- The prescriptions related to many thousands of patients
- The prescribing was carried out in a transactional manner
- There was a serious risk to patient safety, including the risks of overdose and addiction
- This case involved a significant breach of many of the professional standards
- The Registrant was an experienced pharmacist at the time of the misconduct

- The Registrant was also the pharmacy owner and SI, so had the overall responsibility for the safe and effective running of the Pharmacy. He was in a position of trust and power.

333. The Committee considered the following to be mitigating factors:-

- There is no evidence that any patient actually suffered harm as a result of the Registrant's prescribing
- There is no previous Fitness to Practise history for the Registrant
- The Registrant has been in full time practice for almost three years since the misconduct without any further concerns
- There is a low risk of repetition regarding online prescribing
- The Registrant is developing his insight
- The Committee has seen a multitude of positive testimonials (over 50 pages) from health professionals, colleagues and patients. He is very well thought of in the community, and currently runs two pharmacies, providing valuable services to the public.

334. Turning now to sanction, the Committee noted that the Council's 2024 guidance states that a warning may be appropriate where "*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"* but "*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."* However, in this case the Committee decided that giving a warning would be inadequate in response to a case involving serious breaches of professional standards. A warning would not be a proportionate response to the serious misconduct in this case. In addition, the Committee decided that a warning would not be sufficient where there are still concerns regarding the Registrant's level of insight and there remains some risk of repetition.

335. The Committee next considered whether a Conditions of Practice Order was appropriate in this case. The 2024 guidance states that conditions may be appropriate where *"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", and also where "*There is not a significant risk posed to the public, and it is safe for the professional to return to practice but with restrictions".*

336. The Committee noted that the Registrant has been practising under interim conditions of practice since March 2022. The conditions have included that he must not be involved in online prescribing. The Committee has now found that there is still some risk of repetition, to the extent that the Registrant could rush into another business venture without taking time and carrying out due diligence. It has also found that Registrant's insight is still developing. The Registrant only accepted many of the allegations, and said he "*understood where the Council was coming from"* after he had been cross-examined by Mr Corrie. This was despite having apparently reflected on his conduct daily for the past three years. In these circumstances conditions of practice could be appropriate, in as much as there remain shortcomings in his insight which need addressing.

337. However, the Committee notes that the Registrant does not intend ever be involved in online prescribing again, so this is not the case where a period of practice under conditions will allow him to "remediate" his failings around online prescribing. In addition, the Committee looked at the conditions proposed by Mr Summerfield, but they mostly address areas where the Registrant has already provided evidence of remediation. The main concern which the Committee has is in relation to the Registrant's insight as to why the misconduct occurred, and his triggers and motivation for rushing into an agreement with UK Meds without taking time to carry out due diligence. He needs to reflect on that area in order to develop full insight, so that he does not repeat such behaviour in the future if he is ever presented with a similar opportunity (not necessarily online prescribing).

338. The Committee also considered that due to the serious breaches of professional standards, the sheer number of prescriptions involved in this case, and the risk to patient safety, conditions of practice would not be sufficient, as the misconduct is too serious. The public interest would not be satisfied by conditions of practice; such a sanction would not maintain public confidence in the profession or uphold standards.

339. The Committee therefore looked at the next sanction, which is suspension. The 2024 guidance states that suspension may be appropriate where "*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"* and "*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."*

340. The Committee considered Mr Summerfield's submissions regarding the impact a suspension order would have on the Registrant and his family. It noted that he does have substantial savings. There was no documentary evidence submitted to demonstrate the actual impact a suspension would have on the business. Likewise, the Committee had not been provided with evidence as to the amount of profit generated by the walk-in clinic, which is the one service the Registrant has said would be very difficult to continue if he was suspended. There was no evidence regarding the number of patients who are serviced by the private clinic, or the services that are offered, beyond ear wax removal. The Committee agreed with the Council's submissions that whilst it may be difficult for the Registrant, it is unlikely that both pharmacies will need to close whilst the Registrant is suspended from practice. He will still own the business, and can still undertake duties, such as dealing with deliveries, administration, HR matters; it is simply that he cannot undertake the roles of a pharmacist or SI.

341. Having carried out the balancing exercise, the Committee concluded that a period of suspension is required in order to mark the public interest. In terms of proportionality, the Committee was satisfied that this sanction was proportionate, due to the Registrant's roles as SI and RP at the time of the misconduct, the sheer number of prescriptions involved, and the very real risk of patient harm.

342. The Committee has decided that the Suspension Order will remain in place for three months. It reached this conclusion by balancing the aggravating and mitigating factors, and decided that any longer period of suspension would be unduly punitive. The Committee considered that this period of suspension would be sufficient to mark the public interest, taking into account the long list of mitigating factors. This period of time will be sufficient for the Registrant to reflect on this Committee's findings and develop his insight. He has already carried out extensive remediation and CPD courses, and this is not an area which the Committee considered any further work. Any longer

period of suspension would be disproportionate, and would be depriving the public of the services of an otherwise competent pharmacist.

343. Finally, the Committee considered strike off, but that this would be a disproportionate response, and that the Registrant's behaviour is not fundamentally incompatible with being a registered professional. This is not a case involving dishonesty or lack of integrity. The public interest would not be served by permanently depriving the public of a pharmacist who has some insight, and does not pose a serious risk to patient safety, and who is so well regarded by his fellow professionals and patients.

344. There will be a review towards the end of the period of suspension. Although this Committee cannot bind the reviewing committee, it is likely that it would be assisted by an updated written reflection from the Registrant based on the findings of this Committee, to show that he has developed full insight into the misconduct.

INTERIM MEASURES

345. Mr Corrie then applied for an interim measure to be imposed pursuant to Article 60 of the Pharmacy Order 2010 on the grounds of public protection and public interest. The decision of this Committee is an appealable one under Article 55(3) of the Pharmacy Order 2010. There will therefore be a period of 28 days before the Committee's direction comes into effect. Furthermore, during that 28 day period the Registrant could lodge an appeal and, if he did so, the Committee's substantive direction would not take effect until the appeal proceedings were concluded.

346. Mr Corrie submitted that in its decision on impairment the Committee has found that the Registrant continues to present a risk to the public due to his incomplete insight. Mr Corrie said that an interim suspension order is therefore necessary in order to protect the public. He also submitted that an interim order was also in the wider public interest.

347. Mr Summerfield indicated that his client opposed the application. He referred to the unreported case of *Davey v General Dental Council [8 October 2015]* where a registrant was suspended for 12 months, and the committee also imposed an interim suspension order to cover the appeal period.

The registrant in that case appealed the interim suspension order to the High Court, which overturned it. The Master noted that the committee's only reason for imposing an interim order was on the grounds of public interest, due to the gravity of the misconduct. Mr Corrie submitted that the *Davey* case was not relevant as impairment in that case was only found on the grounds of public interest. The Committee agreed that the present case is different, as it has found that the Registrant continues to pose a risk to patient safety (albeit not a high one).

348. Mr Summerfield said that although a possible SI has been identified, it will take some time for matters to be finalised and the Council to approve that person. He said that the Registrant also needed to find a pharmacist and an Advanced Clinical Practitioner to replace him. Mr Summerfield said that all of these steps could hopefully be undertaken within the next 28 days. He said that until the SI is in place, the Registrant cannot open his pharmacies, which will deprive the public of valuable services.

349. The Committee asked Mr Corrie to make enquiries as to how long it would take the Council to approve a new SI. After a break he reported back to the Committee that the Deputy Head of Registration had confirmed that it could take up to 28 days, but they would hope to process the application within two to three working days.

DECISION ON INTERIM ORDER

350. This is a case where the Committee has found that there is incomplete insight, and there remains some risk to the public. The Committee noted that in 2021 the time between the Registrant initially contemplating the business venture and the start of the service was approximately two weeks. The Committee therefore decided that an interim order to cover the 28 day period is necessary in order to guard against the risk to the public.

351. The Committee also considered that in a case where the misconduct was so serious that a suspension order is required, the public would expect there to be interim measures in place during the appeal period, in order to maintain confidence in the professional and uphold standards. In light of this, the Committee has decided that there is a need for interim measures to be put in place

during the appeal period. It is unfortunate that the Registrant's pharmacies will have to close for a short period. but the Committee considered that an interim suspension order is proportionate in all the circumstances.

352. The Committee decided that interim Conditions of Practice were not appropriate for the same reasons as set out by the Committee in its substantive decision on outcome.

353. The Committee therefore determined that the Registrant's registration be suspended on an interim basis until the sanction comes into effect.

354. This ends the determination