General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing Review

Remote Videolink Hearing

22 April and 2 May 2025

Registrant name:	Shahid Hussain
Registration number:	2075141
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Lubna Shuja (Chair) Sima Hassan (Registrant member) Alison McVitty (Lay member)
Secretary:	Zainab Mohamad
Registrant:	Present and represented by Paul Summerfield
General Pharmaceutical Council:	Represented by Matthew Corrie, Counsel (22 April 2025) Charlotte Arduino, GPhC Legal Officer (2 May 2025)
Order being reviewed:	Suspension (3 months)
Fitness to practise:	Not impaired
Outcome:	No further Order, suspension to lapse upon expiry

Documentation

- GPhC Principal Review Hearing bundle (3,424 pages)
- GPhC Combined Statement of Case and Skeleton Argument dated 4 April 2025

- The Registrant's Bundle (98 pages)
- The Registrant's Reflections dated 12 April 2025

Witnesses

- The Registrant, Shahid Hussain
- NM - Pharmacist

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee ('the Committee') of the General Pharmaceutical Council ('the Council'). It is the determination of the Committee of a Principal Hearing Review of a Suspension Order for 3 months imposed by a Fitness to Practise Committee at a Principal Hearing which took place on 7-16 January 2025.

2. The subject of the hearing is Shahid Hussain ('the Registrant') who is registered with the Council as a Pharmacist under registration number 2075141.

3. The review is governed by Article 54(3) of *The Pharmacy Order 2010* ("the Order") *and* Rule 34 of *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010* ("the Rules").

4. The Committee also has regard to the guidance contained in the Council's '*Good decision making: Fitness to practise hearings and outcomes guidance'* (March 2024) ("the Guidance") and the Council's '*Good decision-making: Conditions bank and guidance'* (July 2023).

5. A Principal Review Hearing has up to two stages:

   Stage 1. Impairment – the Committee determines whether the Registrant's fitness to practise remains currently impaired based on the original allegation.

   Stage 2. Sanction – the Committee considers what, if any, sanction should be applied if the Registrant's fitness to practise remains currently impaired.

Service of Notice of Hearing

6. The Committee had seen a letter dated 7 March 2025 from the Council headed 'Notice of Review Hearing' addressed to the Registrant. No issue was taken with service by either party. The Committee was satisfied that there had been good service of the Notice in accordance with Rules 3 and 16.

Background

7. The Principal Hearing took place on 7-16 January 2025. At that hearing the following Allegations were found proved, some on the Registrant's admissions, where indicated:

"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. ***[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; ***[Admitted]***
2.2. relied principally on the information received in an online questionnaire; ***[Admitted]***
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; ***[Admitted]***
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; ***[Admitted]***
3.2. patients were allowed to pre-select the medicine they desired; ***[Admitted]***
3.3. patients provided information primarily through an online questionnaire; ***[Admitted]*** *and/or*
3.4. the service was not subject to appropriate regulatory oversight. ***[Admitted]***

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; ***[Admitted]***
4.2. consider if it was clinically necessary to check with the patients' GP and/or contact the GP; ***[Admitted]***
4.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient; ***[Admitted]***
4.4. consider if it was necessary to check the clinical background of the patient and/or check the clinical background; ***[Admitted]*** *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. ***[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. ***[Admitted]***

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; ***[Admitted]***
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; ***[Admitted]***
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; ***[Admitted]***
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; ***[Admitted]***
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. ***[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; ***[Admitted]*** *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; ***[Admitted]***
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; ***[Admitted]***

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

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; ***[Admitted]***

12.2. patients were allowed to pre-select the medicine they desired; ***[Admitted]***

12.3. patients provided information primarily through a questionnaire; ***[Admitted]*** *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; ***[Admitted]***

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 online questionnaire rather than in accordance with UK prescribing guidance.

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

<u>Schedule A</u>

Date(s) approved of by the registrant	*Medication approved by the registrant*	*Patient Customer ID/ Patient No.*	*No. Approximate number 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"*

8. The background to this matter is set out in detail in the determination of the Fitness to Practise Committee at the Principal Hearing ("the Principal Hearing Committee") and in the Council's Skeleton Argument. In summary, at the material time, the Registrant was the owner, Superintendent Pharmacist ("SI") and regular Responsible Pharmacist ("RP") of Littleover Pharmacy, 141 Rykneld Road, Littleover, DE23 4AL ("the Pharmacy"). The Allegations related to a period between 21 September 2021 and 18 March 2022 when the Registrant was engaged as a third-party contractor for an online pharmacy called UK Meds Direct Ltd ("UK Meds"). During this period, the Registrant acted as a Pharmacist Independent Prescriber ("PIP") issuing prescriptions received from UK Meds' online prescribing portal. The Pharmacy was also engaged in dispensing prescriptions received from UK Meds.

9. UK Meds began operating in October 2017 and was an online pharmacy that used PIPs to issue prescriptions for patients who had selected their medicines 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 PIPs 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 Lead for further consideration. When a PIP issued a prescription, it was then passed to others to be dispensed.

10. The Council's Lead Case Officer had 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, 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 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."*

11. 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. The Pharmacy was one of the community pharmacies to whom UK Meds outsourced dispensing of medicines.

12. Allegations 1-7 related to the Registrant's work for UK Meds as a PIP between September 2021 and March 2022. Allegations 1, 2, and 11 referred to "high-risk medication" which is medicines liable to abuse, misuse or overuse and where there was a risk of addiction. Allegations 8-14 related to the Registrant's work as a SI/RP at The Pharmacy for the same time period.

13. The Registrant's actions across the Particulars had been found to be transactional. It was found that the Registrant had prescribed or approved 36,312 prescriptions during the six months that he had worked at UK Meds. 5,070 of these were for high-risk medicines, of which 2,777 had been issued by the Registrant at The Pharmacy. The Registrant had not contacted patients or their GPs, and there were 717 occasions where supplies had been approved in less than a minute of the order being created by the patient. On 29,886 occasions, the Registrant had approved prescriptions less than one minute after approving the previous prescription.

14. On 14 October 2021, the Registrant had prescribed Amitriptyline to Patient 1. This was done in less than one minute after he had approved another prescription for another patient. Patient 1

had not consented to her GP being contacted. The Registrant had not acted on any of the risks which would have been apparent from the online questionnaire completed by Patient 1. In December 2021, another prescriber at the Pharmacy also dispensed a supply of Amitriptyline to Patient 1. In January 2022, Patient 1 attempted an overdose and at the time the Amitriptyline dispensed by UK Meds was found with her.

15. An expert witness, Dr C, had provided reports dated 20 June 2022 and 15 May 2023 in which she confirmed that the model used by UK Meds was "*unsafe*" as it was not in accordance with the Royal Pharmaceutical Society's Competency Framework. She stated that self-populated patient questionnaires did not give sufficient clinical information to allow for an adequate patient assessment. She also stated access to patient medical records or a discussion with the patient's GP were required and that patients may need face to face assessments particularly if they had ongoing pain. Dr C made reference to the potential misuse of all opiates which prescribers should be aware of, as well as any past or current addiction issues which could be identified from patient medical records rather than self-reported.

16. Dr C concluded that prescribing from a questionnaire without a face to face consultation was not and could not be in a patient's best interests, as the prescriber did not have the full clinical history, and not communicating with a patient's GP was unsafe and contrary to national guidelines.

17. The Principal Hearing Committee noted in its determination in relation to 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 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…… 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.

……..

274….. 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 ……

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."

18. The Principal Hearing Committee found that the Registrant's fitness to practise was impaired due to his misconduct under:

    - Rule 5(2)(a) of the Rules in that the Registrant's conduct presented an actual or potential risk of harm to patients or to the public; and
    - Rule 5(2)(b) of the Rules in that the Registrant's conduct had brought or might bring the profession of pharmacy into disrepute; and
    - Rule 5(2)(c) of the Rules in that the Registrant had breached one of the fundamental principles of the profession of pharmacy.

19. The Principal Hearing Committee noted that the misconduct had taken place in September 2021 to March 2022, nearly three and a half years ago, and the Registrant had continued to work as a SI, RP and Advanced Clinical Practitioner at the Pharmacy and had opened another pharmacy. The Principal Hearing Committee had no concerns regarding the Registrant's current practice which was limited to prescribing face to face with full access to medical records, and considered he was unlikely to repeat this misconduct. It noted that he did not intend to ever be involved in online prescribing again.

20. However, the Principal Hearing Committee did have concerns about the Registrant's level of insight and stated:

> *"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.*
>
> *…….*
>
> *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 [sic], and in particular prescriptions…….. 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.*
>
> *312……. 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.*
>
> *……..*
>
> *315……. 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."

21. The Principal Hearing Committee imposed a sanction of 3 months Suspension to be reviewed before it expired. It observed that the reviewing committee would likely be assisted by an updated written reflection from the Registrant, based on its findings, to show that he had developed full insight into the misconduct.

22. A Case Administrator from the Council had provided the Monitoring Record dated 26 March 2025 which attached an email from the Registrant dated 3 March 2025 confirming that he had complied with the suspension.

Evidence

The Registrant

23. The Registrant had provided a witness statement dated 31 March 2025 together with a Reflection document and notes of meetings he had had with his Mentor. In his witness statement, the Registrant stated:

- He had taken proactive steps to enhance the governance and oversight of his practice. He had meticulously reviewed and updated all Standard Operating Procedures (SOPs), risk assessments and complaints procedures where appropriate. A detailed review of all the policies and procedures at both his pharmacies had been undertaken by an experienced Superintendent Pharmacist, Mr NM.

- The Registrant had undertaken structured professional development discussions with senior healthcare professionals which he had recorded as well as maintaining a monthly diary capturing key reflections, a SWOT analysis, a PESTLE analysis, his future plans and steps taken to eliminate any risks associated with online pharmacy services. He had

completed the Centre for Pharmacy Postgraduate Education (CPPE) Risk Management Guide examining risks within community pharmacy settings and undertaken further CPD courses, evidence of which he had provided.

- The Registrant deeply regretted his past involvement in online pharmacy services. He apologised to anyone involved with his case. He fully accepted the findings of the Principal Hearing Committee and accepted full responsibility for his misconduct. He assured the Committee that he had decided in March 2022 that he would never be involved with a private online platform again and since then he had dedicated himself to face to face patient care. He remained committed to maintaining the highest standards, ensuring full compliance with regulatory requirements and was dedicated to patient safety, ethical practice and professional accountability.

24. The Registrant gave evidence before the Committee. He admitted that he had initially been "*taken aback*" by the Principal Hearing Committee's decision to suspend his practice and the decision had weighed heavily on him. However, over the last few months, he had reflected a great deal on what had happened and why, discussing the matter and seeking advice from two senior colleagues – Mr NM who was an experienced Superintendent Pharmacist, and a Doctor who was also an Executive Director for NHS 111 Derbyshire. The Registrant said that he could see why the Committee had made its decision and respected it.

25. The Registrant's evidence was that there had been several factors which had influenced his decision to enter into the arrangement with UK Meds. His background was in community pharmacy and working with GP practices so he had seen the impact that the Covid 19 pandemic had had on patient needs and timely access to medications during that time. In addition, in August 2021, due to his personal circumstances, **(REDACTED)** he had seen firsthand the impact that Covid had been having on the public. Limited GP access had increased the reliance on community pharmacies, but there had also been a lower footfall at the Pharmacy. He stated that he had thought online prescribing and dispensing would be a pragmatic response to patient needs while also supporting business sustainability.

26. The Registrant stated that financial considerations were also a key factor in his decision although not the only factor. At the time UK Meds was a national company which had given him some assurance, especially after meeting them face to face. They had said they would provide the necessary infrastructure – the online platform, essential IT equipment as well as supplying trained pharmacists and dispensers during the transition period. The Registrant stated that he had had to consider his staffing costs and resources and had felt that the collaboration would contribute significantly to the overall revenue stream of the Pharmacy. The set up costs with UK Meds had been minimal and the Registrant stated that this had been an attractive proposition. The Registrant stated that at the time he had thought about the impact the arrangement would have on his business, but he could see now that looking at the financial side had been "*wrong"* and he should not have jeopardised patient safety, which had, for the previous 14-15 years been at the heart of his practice.

27. The Registrant reminded the Committee that he had ceased the online service in March 2022 and was determined to "*put my practice right from then on*." He had reflected on what he would do differently in future and explained that he would avoid online services, and do thorough risk assessments as well as consider any GPhC Guidance. He stated that he had a good relationship with his GPhC Inspectors and said he would call them if he had any concerns or queries in future. The Registrant stated that he had undertaken a CPPE Risk Management course which had focused on risk in many forms and had helped him to become more conscious about risk and risk assessments. He also now had a Mentor and would discuss risk, due diligence and what to do differently in future with him and other medical colleagues. He explained what he had discussed in professional development meetings with Mr NM, who was his Mentor, on 19 February 2025 and 26 March 2025. He also reminded the Committee that the Pharmacy had had an inspection in September 2023 in which all standards had been met at a time when he had been the SI.

28. The Registrant apologised for his misconduct which had taken place over a period of 5 months. He stated it had weighed heavily on him and he would never repeat it again. He now accepted that he had not been fully aware of all the limitations and risks at the time. He would not have entered into the arrangement if he had been aware of these then. He stated that should another business opportunity arise, he would seek GPhC Guidance, speak to an Inspector first, discuss it with his Mentor and wait, however long it took. He stated he would never rush into an

arrangement again. This had been a life lesson for him and he would never take risks like this again. This had been an extremely intense process which would stay with him for the rest of his life and he cared too much about his career as a pharmacist to allow anything like this to happen again.

29. On cross-examination, the Registrant accepted his conduct had been extremely serious. He said that knowing what he knew now, he would never enter that model again. He accepted now that comparing UK Meds with GP appointments was not a like for like comparison. Although the lockdowns during the Covid pandemic had ended by September 2021, the Registrant stated that the effects of this on everyone had been ongoing and patients had struggled to obtain face to face GP appointments. He referred to articles he had provided which confirmed this. He accepted that he had provided a walk-in clinic which addressed the lack of face to face GP appointments to some extent.

30. The Registrant considered that his personal circumstances, (REDACTED) had had an impact on decisions that he had made at that time. This was combined with the financial aspect. He accepted his risk assessments should have been more thorough and had truly learnt from the lesson. He had held a face to face meeting with UK Meds in August 2021 and they had assured him there would be no prescribing of Controlled Drugs or Opiates. He had done some due diligence but now accepted that his awareness and interpretation of the red flags had been insufficient. After a few months he had realised there were issues and had raised concerns with UK Meds in December 2021 who had assured him that he could safety net and refuse patients, which he had done. The number of prescriptions he had approved had reduced in early 2022. He stressed that his approach would be completely different now. He accepted the model had not been fit for purpose and he held himself accountable for engaging with that model without ensuring the due diligence had been done. Since ending his arrangement with UK Meds, he had put a lot of effort into ensuring his governance aligned with GPhC requirements. The Registrant confirmed that Mr NM was now the SI at the Pharmacy.

31. The Registrant stressed he would never rush into another opportunity again if it arose. He now realised that three weeks had not been long enough to properly consider the venture and he stressed that no amount of financial incentive would persuade him to repeat this. He was not willing to put his family or patients through this again. In hindsight, he realised it had been

rushed and he had overly relied on UK Meds and the assurances they had provided to him. He cared with passion about serving his patients and would not allow this to recur. Patient safety was paramount and he would never make any business decision to jeopardise patient safety. He had changed his practices 3 years ago, not just recently, and he was confident that he could, and had, put things right.

NM - Superintendent Pharmacist

32. Mr NM gave evidence. He confirmed he had been a pharmacist for over 40 years and provided details of his career history. He confirmed that he was currently the SI at the Pharmacy. He had no concerns about the governance at the Pharmacy and was confident staff would contact him direct should they wish to raise any issues with him, indeed he had encouraged them to do so by giving them his mobile phone number.

33. He stated that he had been acting as a Mentor for the Registrant since the Registrant's suspension. They had had many discussions, as well as formal meetings about this case, including discussing patient safety and the Registrant's SWOT and PESTLE analyses. He stated that the Registrant now realised the UK Meds business model was flawed and he understood what steps he should have taken. Mr NM spoke highly of the Registrant as a pharmacist and assured the Committee that, in his view, the Registrant had learnt his lesson and would never repeat his conduct.

Submissions of the Parties

34. The Committee had been provided with a Skeleton Argument from Mr Corrie and a Statement of Case from Mr Summerfield. They both made further submissions.

35. Mr Corrie referred the Committee to the case of Kimmance v GMC [2016] EWHC 1808 (Admin) in which Mr Justice Kerr had stated:

> "*66. There was indeed no evidence of insight and remediation in this case. I do not much like those jargon words. They do not do much to illuminate the reality, which is that a doctor or other professional who has done wrong has to look at his or her conduct with a*

self-critical eye, acknowledge fault, say sorry and convince a panel that there is a real reason to believe that he or she has learned a lesson from the experience."

36. Mr Corrie submitted that the Registrant may still have some doubts about the reasons why he rushed into the arrangement with UK Meds and the gravity of his conduct. Mr Corrie submitted the Registrant continued to rely on his personal circumstances, the Covid pandemic and patient access to GP services during this time as part of his motivation for his conduct. He submitted it was up to the Committee to decide if the Registrant continued to present a risk of harm to patients and the Committee may consider he had not yet fully identified what the triggers were. He conceded that the Principal Hearing Committee had not found evidence of any actual harm to patients and the issues for the Committee to consider were the Registrant's contrition together with the nature and gravity of the conduct. Mr Corrie submitted the Registrant's focus appeared to be mainly on himself, his family and his business rather than on patients. He submitted there was still some way to go and invited the Committee to find the Registrant's fitness to practise remained impaired and required an extension of the suspension with a further review.

37. Mr Summerfield submitted the Registrant was no longer currently impaired and did not pose any risk to patients. The Registrant had given candid evidence to the Committee and had taken many steps to address his shortcomings. He had given financial considerations as the second contributing factor to his decision and had extensively reflected on this. Mr Summerfield referred the Committee to the case of Singh v GMC [2024] EWHC 1741 (Admin) in which Mrs Justice Dias had stated:

"*45….. Insight is insight, whenever it is gained. If the registrant has gained proper and genuine insight by the time of the hearing, I do not see that it necessarily makes any difference whether it dawned slowly or sprang fully-formed like Athena from the head of Zeus in some sort of early "light-bulb" moment."*

38. Mr Summerfield submitted that the Principal Hearing Committee had imposed a sanction of a suspension for 3 months and a longer period would be disproportionate. The public interest would not be met by depriving the public of a competent pharmacist for a longer period of time. Mr Summerfield reminded the Committee that there had been a satisfactory inspection of the Pharmacy in September 2023. He also referred the Committee to the articles provided about

the impact the Covid pandemic had had many months after the lockdowns and to the testimonials provided. He submitted the Registrant had shown full insight and invited the Committee to make no further order.

Decision

39. The Committee considered carefully all the documents provided, the evidence it had heard and the submissions of both parties. In conducting this review, this Committee must review the concerns raised in the original finding of impairment. It must determine whether or not the Registrant remains currently impaired, and, if so what, if any, sanction to impose. There is a persuasive burden on the Registrant to demonstrate that he is no longer impaired or, if currently impaired, to show why either a lesser sanction should be ordered or no action taken.

40. If the Committee finds the Registrant remains currently impaired, under Article 54(3) of the Order, the Committee, on reviewing the suspension, may direct the removal of the Registrant's name from the Register, extend the period of suspension for a maximum of 12 months, or impose conditions on the Registrant's practice. The Committee may also take no action against the Registrant and thereby allow the current Suspension Order to expire, which would mean that the Registrant would be eligible to resume unrestricted practice on expiry on 14 May 2025.

41. The Committee considered very carefully the evidence given by the Registrant and Mr NM having had the benefit of hearing from them both.

Decision on Impairment

42. The Committee first considered whether the Registrant's fitness to practise continued to be currently impaired due to his misconduct. In doing so the Committee considered again Rule 5(2)(a) to (c) of the Rules. which state:

    - Rule 5(2)(a) – presents an actual or potential risk to patients or to the public
    - Rule 5(2)(b) - had brought, or might bring, the profession of pharmacy into disrepute

- Rule 5(2)(c) - had breached one of the fundamental principles of the profession of pharmacy;

43. The Committee considered whether the Registrant's conduct had been addressed, whether it was likely to be repeated and whether a finding of impairment was still needed to declare and uphold proper standards of behaviour and/or maintain public confidence in the profession.

44. It was clear from the Registrant's oral evidence that he accepted his errors and realised his conduct had been serious. He fully regretted entering into the arrangement with UK Meds, had shown contrition and genuine remorse. He had apologised profusely for his behaviour and had spoken in detail about the steps he had taken to address the misconduct. The Committee found that he had given his evidence in a thoughtful and considered manner. The Committee also accepted the evidence of Mr NM.

45. The Committee took into account the views of the Principal Hearing Committee which had had no concerns about the Registrant's current practice. It had not found any evidence of actual patient harm. It had been satisfied that the Registrant was unlikely to repeat his misconduct or use a UK Meds prescribing model again. However, the Principal Hearing Committee had expressed concerns about the Registrant's level of insight as, on the first day of the Principal Hearing, the Registrant had maintained his prescribing and oversight of dispensing was safe, that his due diligence had been sufficient and his risk assessments and SOPs were adequate. He had admitted a number of the Allegations during the course of that hearing. The Principal Hearing Committee had concluded that the Registrant had found it difficult to readily accept the facts proved amounted to misconduct and represented serious breaches of the standards. The Principal Hearing Committee's main concern about the Registrant's insight related to his decision and motivation for entering into the business venture with UK Meds so quickly without carrying out due diligence. That Committee had stated:

> "*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."

46. Having heard from the Registrant, the Committee was satisfied that Rule 5(2)(a) was no longer engaged and the Registrant no longer presented an actual or potential risk to patients. He had clearly identified the triggers that had led to his decision to enter into the arrangement. He had acknowledged that the financial aspect of the arrangement had been one of the factors for his decision and he had spoken about the incentives offered by UK Meds at the time which had impacted on his decision. The Registrant had discussed this at length with Mr NM and had provided extensive Reflection documents where he had analysed in detail his decision to collaborate with UK Meds. He had referred to a SWOT analysis which contained the financial considerations, the potential for business growth during economic uncertainty, patient safety concerns and a future action plan. He had assessed the online model, the regulatory risks that he had not fully understood at the outset and the lessons he had learnt, in particular that patient safety must come first. This was reflected in the evidence he gave, which the Committee accepted.

47. The Registrant had referred again to his personal circumstances which the Principal Hearing Committee had not accepted was a reason for deciding to prescribe online. He had also referred to the impact of the Covid pandemic and his motivation to provide healthcare services to patients who struggled to access these. The Principal Hearing Committee had noted the arrangement with UK Meds had been entered into in August 2021, a year and a half after the pandemic had started and lockdown restrictions had been lifted by July 2021. The Principal Hearing Committee had also not been convinced by the Registrant's explanation that his motivation had been to provide healthcare services to patients in light of this.

48. The Committee noted that the Registrant had provided two BBC articles dated 30 September 2021 and 12 July 2022. The article from September 2021 confirmed that patients were still struggling to get face to face appointments with GPs a month after the lockdown restrictions had been lifted. The July 2022 article stated that the NHS was still dealing with the Covid backlog and demand for services had increased by four times what it was before the pandemic, leading to much patient frustration as they could not get appointments to see their GP. The Committee

accepted that the unique environment at the time, taken with the Registrant's personal circumstances – **(REDACTED)-** may well have impacted on his decision making at the time.

49. In addition, to the extensive reflections the Registrant had undertaken, he now had Mr NM who was a very experienced pharmacist, as a Mentor. He also had a Doctor colleague that he could turn to for professional advice. The Registrant had demonstrated he would have no hesitation in discussing any concerns with his GPhC Inspectors with whom he considered he had a good relationship. He had thoroughly reviewed his governance arrangements, he had attended courses including on risk management, and now had in place all the risk assessments necessary to ensure patients were protected.

50. It was clear to the Committee that this episode had been a salutary lesson for the Registrant and he would be far more cautious with any business ventures in future. Although the Registrant stated that he would never enter into delivering online services again, the Committee took into account the evolving nature of healthcare services and the role that technology is likely to continue to play in many aspects of delivering changing pharmacy services. However, the Committee was satisfied that the Registrant had identified the triggers that had led to his decisions in this case and would not rush into any kind of arrangement or business venture again without fully considering and addressing the risks involved, specifically with regard to patient safety. The Committee concluded that the Registrant had demonstrated full insight as to why he had acted the way he did and there was no longer a risk that he would jump straight in without carrying out the necessary due diligence and risk assessments. As such the Committee was satisfied that there was no longer a risk of repetition or any risk to patient safety.

51. In relation to Rules 5(2)(b) and (c), the Principal Hearing Committee had found that the Registrant had breached fundamental principles of the pharmacy profession and had brought the profession of pharmacy into disrepute. This had been marked by the imposition of the 3 months Suspension Order and the Committee was now satisfied that Rules 5(2)(b) and (c) were no longer engaged.

52. The Committee concluded that the Registrant's fitness to practise is no longer impaired. Accordingly, the Committee made no further Order. The Suspension Order will expire on 14 May

2025.

53. That concludes this determination.