

THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

Transcript of the Public session of the Council meeting held on 27 March 2007

[NB: Decisions in square brackets and narrow type are taken from the unconfirmed minutes of Council and therefore are subject to amendment].

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Present:

President	Mr H Patel
Vice-President	Mr G Alexander
Treasurer	Mr J Jolley
Mr M Astbury	Mr J Buisson
Mr D Carter	Dr B Curwain
Mr S Dajani	Professor S Denyer
Mrs D Drury	Mrs D Eustace
Dr P Entwistle	Mr J Gentle
Mr A Gush	Mr J Hanlon
Mrs S Hikins	Mrs C Hunt
Mrs L Jacobs	Mr R Jobling
Mr A Kershaw	Professor B Michell
Mrs L Morgan	Mr G Phillips
Mr C Ranshaw	Ms M Saunders
Professor M Schofield	Mr D Simpson
Mr D Thomson	

In attendance

Mr P Bennett, Chairman English Pharmacy Board; Mr P Jones, Chairman Welsh Pharmacy Board; Dr Rose Marie Parr, Chairman, Scottish Pharmacy Board

PUBLIC BUSINESS

The President, Mr Hemant Patel: Good afternoon, Council colleagues. Welcome back from lunch.

1. Apologies for absence

We have apologies from Stephen Wells and Seema Agha.

2. Declarations of interest

I would like to take this opportunity to remind Council members they are required to declare relevant interests at the start of a specific item as appropriate.

3. Welcome to guests

I would like to welcome guests from the branches. Dr Wendy Gidman from Central Lancashire Branch, Barry Clark, Treasurer of Sherwood Region and Miss de Val, President of BPSA. Welcome.

4. Minutes of the public business part of the Council Meeting of 15 February 2007

No comments have been received in the office. Therefore can I ask you to approve the minutes?
(Agreed)

5. Matters arising

There are no matters arising notified to us.

6. Secretary and Registrar's report**(a) Report on gazetting of batch 1 of regulations**

Secretary & Registrar, Miss Ann Lewis: This batch of regulations has been gazetted for the required sixty-day period. We have had no comment following that. Can I seek the Council's approval to forward these to the Privy Council for their approval? **(Agreed)** It is, of course, subject to any amendments which the Lords of the Privy Council's may require.

[Council agreed that batch 1 of the regulations be forwarded to the Privy Council for approval.]

b) Minutes circulated since the December meeting of Council

These are for noting. **(Agreed)**

7. Trust, assurance and safety – The regulation of health professionals in the 21st Century

The President: The White Paper was released towards the end of February, *Trust assurance and safety, the regulation of health professionals in the 21st century*. Do you want to give a brief report on the work which has been done since the publication of the paper?

Secretary & Registrar: Council will be aware that the White Paper sets out an intention to set up a General Pharmaceutical Council, a new regulating body, for pharmacy. There is a need to ensure that regulation keeps abreast of developments. We recognise that given the current view, that is the appropriate thing to do. The General Pharmaceutical Council we were glad to note in the White Paper, will regulate pharmacists and pharmacy technicians. It will register and inspect pharmacy premises and will also register pharmacy premises. It will have the same remit broadly as our regulatory functions now. The White Paper also comments on the need for a strong and clear voice "akin to a Royal College" to assume professional leadership. It gives some pointers as to what that College should contain. As I said, the White Paper outlines the intent of the Government to set up a short-term Working Party under the chairmanship of Lord Carter of Coles about proposals for the implementation of GPC. The Working Party is to report to Ministers by the end of March 2007. That is the end of this month. Although there may be a delay of a week or so.

The implications for pharmacy are that the Society will lose its regulatory and statutory role to the new GPC, which will be smaller, more strategic, with wholly appointed Council and will have either parity or a majority of lay members, possibly with an elected chair rather than a President. The Government will be working up the governance, not only for the GPC, but changes to the governance of other regulatory bodies.

The GPC following, as it takes its role in due course, will introduce a revalidation system within five years. The body akin to a Royal College would have, the White Paper says, an important role in revalidation and contribute its expertise to the new GPC, so there would be close working between the two bodies. Arrangements for both regulation and professional leadership in Northern Ireland is to be considered further. The Society and the GPC would retain adjudication but potentially draw Panel members from a central list in due course. You will recognise that the Society has actually had separate adjudication for many years, so others are moving to the model which we have.

The GPC would retain responsibility for educational standards and the GPC in due course would record postgraduate qualifications or postgraduate specialisations where relevant.

I think probably I should inform the Council that the Council appointed four members to Lord Carter's working group. They are the President, the Vice-President, Mr Phillips and Mr Hanlon. They have been attending the meetings of the Working Party. There have been five to date and there is one further meeting before the Working Party's work is concluded. In addition to that, the Department have commissioned an economic evaluation which will be part of the information for the Working Party. They have held a meeting to begin to define functions of a Royal College. At the moment, President, we have undertaken quite a lot of activity particularly in relation to communications. That is indicated on page 3 of paper C/15. In particular, there is statement on publication of the White Paper. We have had responses to numerous press enquiries. Letters for publication have appeared in the pharmaceutical press and features which are due to appear in the near future will include in the C&D, Pharmacy Magazine, Pharmacy Now and Pharmacist, which is a new publication due out in May. Possibly one of the most significant meetings was the Society held a meeting with branch members

and members of other bodies on 9th March to discuss the implications of the White Paper and the pharmacy press was invited to that.

The President gave a follow up meetings and individual briefings to PJ, C&D and Pharmacy Magazine. I think it is true that the White Paper proposals have placed considerable demands on the Society's resources, both human and financial, and the costs will also include the Society's own due diligence exercise. Suffice to say we also set up an advisory group which includes Council members, in addition to those on the Carter Working Party, in order that they might take advice from a wider group of people, recognising that it was not possible for the whole of Council to be involved at each stage. But Council themselves have been informed and have received appropriate information.

We did have an additional Council meeting in February and this is the first opportunity at a full Council meeting for Council to receive the information formally. At this stage, until we have the report from Lord Carter's Working Party, it is probably as much as I can say at this stage. But you may wish to add to what I have said, President, or to answer questions.

The President: Thank you, Secretary and Registrar. I want to begin by covering two items which occurred even before the White Paper was published. One was the Society's initiative Pharmacy 2020, which was to look at what is happening in the wider healthcare arena now. We have positioned pharmacy so it is fit for purpose in 2020. We were looking, and are still looking, at all the different areas which would affect pharmacy education and pharmacy practice. I believe the Royal Pharmaceutical Society is the best organisation to bring science and practice together.

The second initiative which is quite an important initiative under the chairmanship of lay member Bob Michell was *Scoping the Profession*. The whole purpose of that exercise was to understand what practices are taking place in pharmacy, what groups are formed, what their needs and desires are for the future. So we had started to plan for the future, following a very successful PIANA exercise that started about 10 years ago.

Since the White Paper was published, the Secretary and Registrar has covered most of the ground which I wanted to see covered, but I would like to add two things to that. One is that we welcome the opportunity to help the pharmacy profession to become more clinically orientated. I think that is the wish of pharmacists and we will do everything to make that happen. Then in this big task, we will work with every organisation within pharmacy and outside to make sure that the future of pharmacy is secure and pharmacists find meaning and enjoyment in the work that they do.

In terms of publicity, we have taken every step to inform the Council and the Society's employees of what is going on. Also, we arranged a meeting on 9th March that the Secretary and Registrar talked about. We will be in touch with the branches and regions and members at an appropriate time when the information is ready to be shared. But there is one area that I am concerned about and that is the interface issue between the GPC and the Royal College in due course. At the present time, as an integrated body, that interface has been easy to manage. Effective working and communication between the GPC and the Royal College would be crucial to the future development of the profession. Areas where the Royal College might work with the GPC includes, but this is not an exhaustive list:

- the development of standards of practice and performance
- The development and delivery of standards of education and training
- The promotion of standards of conduct and ethics
- Support of CPD including facilitation, reviews and continuing education and skills development training
- Support for revalidation, which is going to be crucial in three to four years' time, both to meet the initial revalidation requirements and the additional support for those whose initial assessment is not satisfactory.
- Support for those wishing to return to practice after a break and or to advance through specialist levels of practice, support of clinical supervision, mentoring and [inaudible], support for early days of practice and movement between specialisms and areas of practice
- Support for students and overseas applicants wishing to seek registration with the GPC.

I focus on this interface issue because it clearly demonstrates that the GPC and a body like a Royal College must work together. If the public and profession is to benefit, we must pay maximum

attention to this interface area.

In terms of working as a member of the Carter Working Party, I am extremely proud of the papers that the Society has produced and I am sure that they have benefited the Carter Working Party. That was recognised by Lord Carter at the last meeting. That goes to show that the Society's staff are of a high calibre and have worked under extreme pressure to meet the deadlines, and we can be proud of the work that has been done to date.

What I would like to do is to take comments or questions the Council has on this particular item.

Professor Bob Michell: Two comments. First of all, I think you are right to emphasise the importance of the interface between the new bodies. I think this will be clearly demonstrated in one of the key areas, which is revalidation. Because setting up a revalidation scheme is extremely demanding on resources, both in setting it up and also in delivering it. I think that the introduction of revalidation is likely to be substantially delayed by the fact that it will have to be negotiated between two bodies with different interests and both finding their feet, and that is clearly not in the interests of patients. Patients actually would probably be much more interested in revalidation than in what the organisations are going to look like.

The other comment is more important. Members have heard it before, but I would like to place it on record in public business. What is arising from this new approach to healthcare regulation is a radical reform of both the regulation of pharmacy and the representation of pharmacists. It is in everybody's interest to get that right. I therefore would dearly love to know what is the most motivating force for the inordinate haste with which the negotiations to establish these new bodies have been conducted, and which we heard amply chronicled this morning; much of it appearing to be decided on the hoof and quite differently to the original intentions of the meetings. As someone who is here to represent the public interest, I do not know whose interest this inordinate haste is in. It is certainly not in the interests of the public, at least the public in the sense of patients.

The President: Thank you, Bob. I am not able to answer your question, because you and I do not understand the need for such a haste. But we have to work with the Government to ensure that the Society makes appropriate representations when they are necessary.

Professor Bob Michell: May I make an additional comment? If there is doubt about the dangers of such haste, we only have to look at the track record of the Department of Health on things that it has done in haste. The three outstanding examples are the introduction of a changed basis for out-of-hours care of patients, which has been proved hugely expensive to introduce and is going to be hugely expensive to put right. The second is the cack-handed way that the centralisation of patient records has been handled. The third has been the inept way in which the training scheme for young consultants has been mishandled. None of this gives as any confidence that things that the Department does hastily are done well, either in the interests of patients or actually in the interests of tax-payers.

Professor Stephen Denyer: Mr President, your introduction to this paper was very useful because it is indicated how much movement we had been making towards the White Paper's intentions, at least in terms of our relationship with other groups that exist supporting pharmacy. I think it is important -- and it is not stated in the paper -- that much of the reason behind the White Paper is to achieve consistency across regulators. It is not a measure or indication of any lack of achievement or lack of success that the Society has had. Indeed, it has been at the vanguard of anticipating Government's intentions and better regulatory and professional practice. I feel that we are starting from a position of strength in that regard.

The President: Thank you, Stephen. You are of course right in that, because CHRE has consistently given us a clean bill of health. I think we are leaders in many areas of regulation, and I think that has been commented in the report from CHRE.

Mr Sid Dajani: I realise a lot of this situation is not of our doing, and is not the doing of lack of public confidence and is definitely not the doing of individuals within the profession or a group. That has already been stated on public record by the Chief Pharmacist. It is basically the political regulatory

horizon for the current time.

I think it is very important that we stress the communications that have emanated from this building have done so at the earliest opportunity, when we were allowed to do so. I do not think anyone should complain that we have not done it sooner.

The President: To clarify that point, we were asked not to discuss various points emerging out of the White Paper until given clearance from the Department of Health. Thank you for clarifying that.

Mr Sid Dajani: The consultations with the profession have to be as early as possible and as well informed as possible. So therefore the choice given to the members is going to be fundamental to this process. I think the one message I would like to totally come out of this is that although the pharmacy family makes the profession, we must not allow pharmacists to lose their professional identity within this. It is the profession which has driven a lot of the good work that we have done. It is the pharmacists who have been allowed self-regulation through statutory legislation to do the good work that we have done. I think it is very important that we recognise that pharmacists in their own right have an expertise, have a specialty, will benefit the public. We are so diverse in the roles that we do. If we dilute that any further, then we will not end up with a pharmacist led organisation or even as a College or even as a profession. I wanted to make that clear too.

The President: On your point on consultation, I give you my assurance that it is our desire as Officers to ensure that consultation takes place at an early stage. You recall that following the publication of the White Paper, we immediately called a meeting of branch representatives at Lambeth on 9th March. But we cannot win. And sometimes we fall between two stools. When the meeting was called in such a hurry (as some people called it) some people did not like it and wanted more time. Then there were others who were saying we must call a meeting as soon as possible. In some ways I think what we will have to do is call a meeting, or take action, at the earliest possible, opportunity taking into account all the different logistical areas that we need to consider.

Professor Michael Schofield: The Minister responsible for this in the end is Lord Hunt, as we know. I worked with Lord Hunt in NAHACT, which became the NHS Confederation. One of the things which we were very concerned to do was to keep in touch, not just with Government, (primarily with Government of course) but also with the opposition. So he and I used to have regular sessions with the Opposition Health Spokesman and other colleagues. So I would like to flag up the notion that at an appropriate time, and in discussion with our people responsible for lobbying across the river, a dialogue with the Opposition people might be a good idea, for two reasons. First because, as this evolves, they are able to ask relevant questions which might be helpful to us. Secondly, because you never know with the legislative timetable. It may that we have a set of proposals which are drawn up by one government which may fall to another one to introduce. The more you can build the dialogue beforehand, the more helpful it will be. So there are sensitivities, but certainly Phillip Hunt recognised the sensitivities in the past, and felt that he had a duty to work with all three actually, but certainly both of the major parties. I would like to put that into the mix for you and the Secretary and Registrar to think about and at an appropriate point maybe take it forward.

The President: Thank you, Mike. That reminds me. I should have reported it. We went to see Andrew Lansley, the Opposition Health spokesman, together with David Pruce, Director of Practice & Quality Improvement. We briefed him as much as we could, but there were limitations there. Sandra Gidley MP is a member of the Carter Working Party, so I think at the present time we have covered the areas. But I do take the point that you make. I thought you made the point very well.

Secretary & Registrar: In summary -- and it is helpful that Professor Michell raised the political engagement, because we have met Lord Hunt. The President has also written to the Secretary of State and indicated the principles which the Society believes will underpin the formation of both the GPC and the proposed Royal College. I think we should repeat them here. They have already been part of our press statements, but those principles are worth restating. Firstly, the new arrangements ought to improve on current structures, leading both to improved public and patient safety and the stronger professional leadership for pharmacists. I think it is worth pointing out that we are saying "public and patient safety". "Much of the White Paper focuses on patient safety, but we are actually serving the public as a whole. The transition to a GPC and the possible establishment of a Royal

College needs to be properly managed and resourced. This would be a major exercise.

Structures for both regulation and professional leadership need long-term financial sustainability. Strong and transparent governance arrangements will be needed both for the regulation and professional leadership of the pharmacy profession. The fifth point: The pharmacy profession and other stakeholders ought to be fully considered and consulted during the process of change. As the President has indicated, the Society will be doing all it can to keep consulting members on these changes and to take feedback on board from all the key stakeholders. I think, President, you have outlined exactly what steps we have taken to date to do that.

The President: Another point I wanted to make was that the four nominees chosen to go to the Carter Working Party were not chosen for their background at all. They were chosen for the posts they hold at the Society. I was invited as President. A lay member was asked to be nominated and John Hanlon was invited to join the Working Party as the Society's nominee. The Vice-President was invited because he was also the Chairman of RMC and Graham Phillips because he is the Chairman of Education. I have to say that that combination has proved to be correct so far. Can I ask Graham Phillips to make his comments and then Bob?

Professor Bob Michell: Because for family reasons I have been somewhat of a spectator of these negotiations, one of the things that has struck me as outrageous with all the nonsense of openness, transparency and all the rest of it, is that these negotiations have been conducted as if they concerned the future concealment of weapons of mass destruction. **(Laughter)** Everything possible has been done to gag those involved in the negotiations to thoroughly prevent timely consultation with the membership. Frankly, as someone who is a member of Council, it has given me great concern that so much effort has gone into preventing us from consulting the membership and perhaps also leading their opinion towards the new realities.

The President: Thank you, Bob. John, as the lay member of the Working Party, do you want to say anything?

Mr John Hanlon: I would like to put on public record what we have said, which is in the minutes of our last meeting. We have said, to allay concerns about this, very clearly that the four members cannot bind the Council, and for appropriate measures that require membership to decide on, the membership will decide. I think that is very important that we reassure people here and the wider membership of the Society that that is the case.

The President: With that I would like to wind down the debate on this important and historic development and move to the next item on the agenda.

[Council noted the report.]

8. Draft regulations on special resolutions

Council is asked to consider and agree the draft regulations on special resolutions for submission to the Privy Council advisers. Within your bundle of papers under C/16, you have the special resolutions. To take us forward, Christine Gray, head of Corporate Governance, will introduce the item. Then John Hanlon, Chairman of Governance committee will present comments from that Committee.

Mrs Christine Gray, Head of Corporate Governance: If I can take you to paper 16 in your bundle. You will be aware that article 12 of the Charter requires that Council decisions on certain defined subjects must be confirmed by special resolution in accordance with the regulations, either at a general meeting of members of the Society by not less than a two-thirds majority of the the votes of members present in person or by proxy or by ballot of the membership and the types of decision that need confirmation by resolution are new category of membership of the Society, any application by the Society for a change in Council composition, any alteration to the Charter, any change to the Society's name and the surrender of the Charter and dissolution of the Society, including the destination of any residual assets. So the Charter actually requires the creation of regulations on the procedure for special resolutions. So a special resolution cannot be processed until regulations covering this are in force. Obviously the Council could make a decision and seek the approval of

members of the decision in some other way, but if there were no regulations in place legitimising that, and a special resolution it would have no standing under the Charter. You will be aware that no regulations covering special resolutions are in force at the moment.

Given the current discussions going on with the Government, it seems possible that the Council might want to seek confirmation of a decision or decisions by special resolution, in the not too distant future. Bearing that in mind, the Officers have recommended that the normal process we go through for bringing resolutions to you for approval should be shortened in this instance, as set out in paragraph 2.1 in your paper. Can I first ask whether the Council agrees recommendation (i) about the procedure being shortened for this particular set of regulations.

The President: Is that agreed? **(Agreed)**

Mrs Christine Gray: I will now go to the draft regulations themselves. This paper was circulated in advance to members of the Governance Committee.

I will hand over to John Hanlon do talk us through issues raised by members of that committee.

Mr John Hanlon, Chairman, Governance Committee: Thank you, President. Perhaps if I could ask, Averil if you have the slide for 3.1. Can I draw members' attention, to the change which is on your page in 1(iii), which was one of the items very helpfully raised by Graham Phillips. This was the suggestion that "by a two-thirds majority vote of the members voting electronically or in a postal ballot or by a combination of both methods as determined by Council." The suggestion is that we take that power now, but that we will probably not use that method of getting the view of the membership until such time as we are sure about the process. It seems sensible to take the power to do so now. So that is one change I would like to draw to your attention. I know Graham has a couple of other points he wants to raise, but I think Christine has dealt with most of them I think in relation to page 1 of 3 and 1 of 4. It is quite clear from the Charter under Article 12 that there are defined subjects that require a two-thirds majority. Christine has enumerated what they are. They are in 1 of 4. The comments I received were mostly from Graham. I am sure he has questions to ask. But I do think the two-thirds majority subjects are quite clear in the paper and quite clear in the Charter.

Mr Graham Phillips: Let me first say that I support the direction of travel of this paper and I am happy to see the amendment, which is the most fundamental which I wanted. I have one concern and no real answer to it. When we were debating the Charter the idea of a decisive vote would have been by simple majority. We have extrapolated that to mean two-thirds of those voting. My concern is the potential for stasis. I am not sure of the answer to that, but I think we need to be aware of what we may be achieving there or not. My other concern is 3.2 which members might want to reflect upon briefly. My reading of the paragraph is somewhat paternalistic and I wanted reassurance as to exactly what the implication of paragraph 3.2 may be.

Mrs Christine Gray: Can I go first to paragraph 3.2 where you are suggesting it is paternalistic. The paragraph has been drafted in the light of expert legal advice and all decisions requiring confirmation by special resolution must, by their nature, be considered to be fundamentally important. That is why that was set out in the Charter. So these must all be put to the membership for confirmation one way or another. The paragraph suggests the Council would need to have proper regard to the relative scale and importance of the proposal and whether the need for open debate had been adequately met when considering the method by which the members' consent should be sought. I would like to emphasise that it does not in any way suggest that some decisions requiring confirmation by special resolutions must be considered to be unimportant, and that Council might somehow bypass due process. That is not possible. All those decisions I mentioned must be confirmed by a special resolution to that effect:

The President: Are you happy with that, Graham?

Mr Graham Phillips: I think I can be reassured by that. It is on the record.

Mrs Christine Gray: On the two-thirds majority, again it is something upon which we took advice. I think it is quite common where there are the fundamental type of decisions that something more than

a simple majority is generally required. In fact we have been advised that it may be unlikely that the Privy Council would not be willing to approve a simple majority for a decision such as these.

The President: Can we agree (ii), which says "subject to the Council's agreement to (i)," which we have agreed, "the Council is asked to agree the draft regulations at 3.1 and submit the regulations to Privy Council's advisers for comment."

Mrs Christine Gray: With the amendment to allow for the possibility of electronic voting, are you content for us to submit this to the Privy Council advisers for comment? **(Agreed)**

The President: Can we go to the next item, which is to be introduced by the Secretary and Registrar.

[Council agreed (i) on the recommendation of the Officers, that the procedure for creating regulations on Special Resolutions be shortened as set out above, and (ii) subject to an amendment to allow for electronic voting, the draft regulations for submission to the Privy Council's advisers for comment.]

9. Erasures

Secretary & Registrar: I would seek the approval of the Council to remove from the Register those pharmacists and technicians who have failed to comply with the annual retention fee requirements? We will be circulating on the table a copy of those named. Are there any questions? The Head of Registration, Andrew Gardner is here. I should point out that these names and this direction are being conducted under our original legislation which was in force at the time of the due date for retentions, which is 1st January. These are those who have not complied within due time. From now on, we will be working under the new legislation under the Pharmacists and Pharmacy Technicians Order, but this is conducted under the old legislation for point of clarification.

Mr Jonathan Buisson: Just for information, could we say how many of each are being erased and whether it is more less than last year.

Mr Andrew Gardner, Head of Registration: There are 402 pharmacists being removed and that excludes 24 people who have not paid, who are under investigation at the moment. In 2006, there were 584 that were removed from the Register and in 2005 there were 875, so you can see there is a reduction of the number being removed. There is 50/50 split in terms of practising and non-practising. 20 percent of those are non-practising in GB; 28 percent overseas; 37 percent practising and 12 percent were new registrants. 50 percent are in England and 50 percent are overseas. There are a few in Wales and a few in Scotland. It is about 57 percent are women and I think about four Fellows on the list.

Secretary & Registrar: By that you mean Fellows by designation!

Mr Andrew Gardener: I have a list of pharmacy technicians who should have been removed on 1st January under the Pharmacy Technicians Protocol. We have allowed them to remain on the register and we are now asking Council to agree their removal.

The President: With that, can we agree the erasures from the Register of the two lists given to you to date? **(Agreed)** We will take the next item at 3.30.

Secretary & Registrar: Can we explain for those who are attending, this is because Professor Professor Sheila McLean, who has chaired the group, will be here at 3.30. So we will be moving on to 10(b).

[Council resolved to instruct the Registrar to remove from the Register (i) those pharmacists from whom an appropriate payment had not been received, in accordance with Byelaws section II (11) (and remaining in force until the new registration rules were made under the Pharmacists and Pharmacy Technicians Order, 2007), and (ii) those pharmacy technicians on the voluntary register who had not made a retention fee payment by 23 March 2007.]

10. Referrals from Law & Ethics Committee**10(b) Consideration of cases for non-referral to the Infringements Committee**

The President: 10(b) will be introduced by Doug Simpson. The item relates to consideration of cases non-referral to the Infringements Committee.

Mr Douglas Simpson, Chairman, Law & Ethics Committee: In December 2006, the Council asked the Law and Ethics Committee to assess whether a single dispensing error is likely to amount to professional misconduct and referred it to the Infringements Committee. The Committee has developed material outlined in section 4 of the paper, which I am sure you can read. It is proposed that a single dispensing error should not be referred to the Infringements Committee unless one or more of the criteria are met. You will see what they are. The Law and Ethics Committee recommends that cases not referred to the Infringements Committee should be disposed of by way of letter sent to the individual by the office. Records will be maintained to show that the individual has admitted the allegation made and accepted the advice provided, It is also recommended that cases which are not referred should be audited and the criteria for non-referral be continually reviewed. So there are a few fail-safe procedures in there. We can all see the kind of cases which would not automatically be referred to the Infringements Committee in section 4.

The President: I will hand over to the Vice-President for a minute or two. I have to sort one or two things out.

The Vice-President, Mr Gerald Alexander: In the meantime I will chair the meeting. I am going to ask the Council how much discussion we want to have on this item. If there are questions, I know the Chairman of Infringements Committee is here. Do you have any specific comment you would like to make, Phillida?

Dr Phillida Entwistle, Chairman Infringements Committee: I have two comments but nothing controversial. We think it essential that we keep a record of what happens and how effective it is. The other thing is that the Infringements Committee will be soon replaced by the Investigating Committee within the next few days. We do not want to allow the Investigating Committee to lose the momentum by thinking up of other issues that could be sent straight to the Inspectorate. We need to have some mechanism in place to ensure the Investigating Committee does what Council expects them to do.

The Vice-President: Can I ask the Director of Fitness to Practise to comment on that? How will that knowledge be conveyed to Council in the future?

Ms Mandie Lavin, Director of Fitness to Practise & Legal Affairs: This was a raised by the Infringements Committee at a meeting this week. We will continue to do what we have always done, in terms of producing Law & Ethics bulletins on matters that arise as a result of cases that we see, which will ultimately go to the Investigating Committee. We will still continue to produce the fact sheets which we produce in terms of areas of commonly asked questions that come through our advisory service. I think the question that has been posed by the Infringements Committee is slightly broader. Clearly this initiative came from a recognition of some of the current anomalies in the law, and how the Society can move to perhaps take a more pragmatic approach in the safeguard of audit and criteria which are clearly set out. An important part of this paper is that it has ... **(inaudible)**... to a one-off dispensing error. The other important point is the criteria and the third element of audit. I think the broader question about in effect future policy momentum is a matter ultimately a question for Council.

Professor Stephen Denyer: A request for clarification on item (iii) of the recommendations. It says under (iii): "Cases which are not referred should be disposed of by way of a letter sent to the individual by the office as a result of the findings of the inspector's investigations, where the individual admits the allegations made and accepts the advice provided." What happens if the individual does not admit the allegations or accepts the advice provided?

Ms Mandie Lavin: I think that is the point I was making. There has to be an admission for the process to kick in. In the event, that the advice is -- I can envisage there may be occasions where the advice itself may be amended because of some factual issue. But ultimately there has to be

admission of the error and acceptance of advice.

The Vice-President: You are satisfied with that.

Professor Stephen Denyer: I am.

Mr Graham Phillips: Can I take us to page 4 of 9, item (iv) criteria for assessing whether dispensing error amounts to professional misconduct. What I think we are trying to achieve here is a no blame culture, and recognising that human beings are human beings and will always make a level of error. That is a simple fact. The first concern I have is that a dispensing error “where there is a potential for evidence that the dispensing error caused moderate or severe harm would be treated different.” A dispensing error is, at the end of the day, a dispensing error. So I think the risk of is that we will continue to bury the error under the carpet and more so. The last bullet point: there is relevant history within the last three years. I cannot imagine there is any pharmacist in the country working at a steady pace who has not made a dispensing error within the last three years.

The Vice-President: Could I stop you? It is just that the relevant history may not necessarily pertain to a dispensing error. Perhaps Mandie can interject.

Ms Mandie Lavin: Drawing up this criteria has been an immensely difficult job. I would perhaps assure Council of two things. Firstly, this is the starting point. We have already told you we are going to be auditing this. I think it is very likely that we will have to revisit the criteria. These are criteria that are currently being suggested to Council. Ultimately the Investigating Committee I am sure will have their own views and through their experience of working and looking at the sort of material that comes through their hands, they may also have suggestions for change. I would not suggest it was absolutely perfect for one moment. I think it is about as perfect as we have managed to get it. The points from the floor are very well made. I have absolutely no doubt that this needs to be revisited.

But it is a step in the right direction and I would be quite disappointed if there are any show-stoppers here. If we had to do more work on it, I think would be rather difficult.

Mr Graham Phillips: I do support the direction of travel of the paper. As a practitioner, I need to be realistic about what actually happens in practice, and whether we are going to achieve the outcome we seek here. With those two concerns remaining, I do not think we should stop the paper going through, but we have to address the realities of practice and not take this from an ivory tower perspective. The reality of practice is that errors are made. You cannot be selective about the errors you make, and we all make errors. Therefore a relevant history within three years could mean anything, but it could include virtually every pharmacist in practice.

Mrs Lorna Jacobs: Picking up on what Stephen said on 3. I would like clarification. It says: “Cases can be disposed of by a letter and (...) accepted the advice provided.” I would like to be a little clearer about what the letter would say. In other words, this is in the spirit of a criminal offence and it would be learning from and it would be sad if the tone of the letter ended up being an admonishment effectively; too much of a slap on the wrist.

The Vice-President: I would guess from my experience that it is a standard form, but perhaps Mandie to clarify.

Ms Mandie Lavin: Indeed we have devised a standard template and what is really important is that it is not in effect an admonishment by default. But what is important are the elements of admission and acceptance. Clearly the basis of the procedure is that the individual recognises there has been a problem and is happy to take advice and seek to remedy anything which needs to be remedied.

The Vice-President: How do you feel about that, Lorna?

Mrs Lorna Jacobs: Only whether there is any way of ensuring that that is clear, so that the tone does not deviate from that to become punitive.

Mr Jonathan Buisson: I wanted to lend support to the point that Graham Phillips raised, particularly

bullet point 1 under 4. Judging by headlines that result from the case, not from the circumstances that led up to the error.

Mr John Hanlon: I do not think any member of Council should underestimate how difficult it has been to get to the stage we have got to. I think it is taking things quite a bit forward to where we were a few months ago. I have a question. I think we should remember this, that we have agreed with Council that we would raise with Government about the legal status of a dispensing error. It is really to ask, again for the purpose of the record, have we raised it with Government? I suspect not, but have we at any rate either a preliminary or substantive response to that as yet?

Secretary & Registrar: I have raised it. Does Mandie want to answer specifically? We have raised it several times.

Ms Mandie Lavin: Indeed. We have the support of many other pharmacy bodies including MPSA and the Guild of Healthcare Pharmacists. As we speak, some of my team are drafting a comprehensive Parliamentary briefing in response to a letter we have had in on this point. Progress is being made. It is good to see the world of pharmacy responding to something that clearly, speaking as a lawyer, it seems to be the difficulty between the reality of practice and the legislation which clearly was drafted in 1968.

Secretary & Registrar: Just to add to what Mandie said, the letter came from the Chairman of the Health Select Committee. I asked for the briefing to be drafted because he says he intends to take it up too. So I think you can be reassured. As soon as the briefing has been completed, because they had drafted a response I said, "You need something much more substantive than this." As soon as it is available, we will circulate it to Council members.

Mr John Gentle: A point of information. At the end of background on page 2 of 9, the last paragraph: "It is proposed that during 2007 the Infringements Committee will give consideration to other types of cases identified by ... **(Inaudible)** that may be suitable for local resolution, if clear criteria are in place." Bearing in mind that yesterday was the last meeting of Infringements Committee, the proposal of how that work should continue would go to the Governance Committee.

I believe they are scheduled to meet on 30 April, and a decision will be taken then on where that will continue, because there will be no more meetings in 2007. Following on from Graham and Jonathan's point, back to the first bullet point on item 4, page 4 of 9, which talks of whether the dispensing error caused moderate or severe harm, which is a significant difference to the way Infringements Committee treats cases at the moment, whereby the consequences of an error are not taken into account. Because, as John said, the learning points from making the error are from the run-up to the error, and not what happened after the error was made. And whether the patient took the drug or took the drug and suffered consequences which were minor or serious, or whether it becomes a newsworthy case in the headlines, as John mentioned, is irrelevant as to how the error was made, and therefore the way the Society treats cases like that at the moment take no regard to the consequences of the error; simply the error itself. That does appear to be a significant difference; that the penalty the pharmacist will suffer depending on the circumstances of the error and not the error.

Dr Brian Curwain: What I think I read behind the bullet point is that actually the dispensing of certain drugs and medicines is more hazardous de facto than others. It is really trying to suggest that we should be in a way obviously taking extra care with drugs like methotrexate and so on, where it is really very, very easy to kill people. I can see another point why we need to leave this bullet point in place for the moment, at least until we see how it works in practice. That is the perception of the public. If somebody actually dies as a result of a dispensing error, the public are going to want a proper investigation to see due process; not just a quick letter to the pharmacist, saying, "Don't do it again." I think for that reason the bullet point needs to stay, until we see how it runs in practice.

The Vice-President: Anybody wish to speak against it?

Mr Douglas Simpson: The word 'potential' appears here. Potential means that the actual harm has not arisen. We are trying to achieve a pragmatic approach. I think Council in previous debates has

been concerned with every last infringement and every last misdemeanour; clogging up the process and really making the whole thing impossible. We are just trying to introduce a bit of practicality. In that practicality, we have to recognise that some errors have potential to cause more damage than others. That is the reality of life and that leads to the big headlines that Jonathan was talking about. But we do not actually say the death or serious injury has had to occur; we are talking about "potential to" which picks up the point Brian is making, that some drugs need a great deal more care than others. We are just being practical and pragmatic and I hope the Council will accept it on that basis.

The Vice-President: Looking at the recommendations on page 1, the criteria set out in 4, is there a need for further discussion on those criteria.

Mr Martin Astbury: Do you have an amendment?

Mr Alan Kershaw: You are limiting this to the bullet points.

The Vice-President: We have moved on, I think.

Mr Alan Kershaw: If I may continue. I think this is exactly the right direction to be going in. I think we need to remind ourselves, looking at the bullet points, that in getting us to this stage with this recommendation, this is the Infringement Committee giving us the benefit of its experience. It will get experience from the new dispensation, or the new committee will. And on the basis of that it, will no doubt recommend changes to criteria as it goes along. All that is being proposed is not that you will be disciplined if one of these bullet points applies, but that it will go to the Infringements Committee. Therefore they will be quite capable of taking no action, or mild action to action similar to the letter. They will do it in the circumstances of each case, and on the basis of that experience they will come forward with recommendations for new criteria. That is the right sort of thing. As to the flavour of the letter that will be written here, the sort of term being used by other regulators is something like consent orders.

No-one used the word 'order', but consent is quite important. It is about working in collaboration with the individual who has transgressed in some way, with their agreement, to mend their ways and do things better in future. That is exactly what fitness to practise procedures are supposed to be about, or should be about, in a proper world and not simply about punitive action. Finally I would like it formally recorded in the record of this discussion, because I think it is the favour of what people are saying. Not only that we note that more action is planned, in terms of finding new areas which might be dealt with by this kind of process, but that the Council expects that to be so and we shall look for evidence of it in the future.

The Vice-President: I think you capture the sentiment of the Council, thank you.

Mr Ray Jobling: I want to support all that. I think it is very important progress and people are calling it pragmatic. Yes, of course it is. It is moving it forward. Errors represent a huge threat. We know that is the case, but it is not the fact of the error; it is the root causes one should not lose sight of. It is not the reporting of the error per se that matters for improving safety, but responses to the reporting. That is the context. That moves it forward in this way, but let us not lose the big picture. Of course you must keep it on under review. I would like it on record too that lay members supporting this is a step forward in public safety. That is what it is. It serves the profession, but it is really it is serving the public safety to move in this direction and decriminalise errors. The present system works against public safety because we are not learning from errors.

Mr Sid Dajani: I totally support the paper. I would like to go ahead as soon as possible. It does not dent the public interest. It does not abrogate accountability. It means it is more pragmatic and it means that we can do the job properly in the patient validated role. We should get on with it, approve it, agree it and get on to the next agenda item.

Mr Andrew Gush: If a pharmacist, after listening to the results of an inspector's investigation, elects not to admit the allegation because he believes it not to be true, or to take the advice, this should not prejudice any further investigation against him. I think that is quite important.

The Vice-President: We can take that into account.

Professor Bob Michell: I think we have to recognise that in all walks of life, it is not just making the error that matters but the consequences. If a builder drops a hammer and it hits the pavement, the consequences are trivial. If a builder drops a hammer and it hits my skull, the consequences are entirely different.

Professor Michael Schofield: It wouldn't make any difference, Bob! **(Laughter)**

The Vice-President: Given that we have standing orders where Council members are only supposed to speak once, Lorna, you have spoken once, but is there a question?

Mrs Lorna Jacobs: It is to do with the clarification of appendix 2 and the definitions. My concern was that the definition -- sorry to sound trite of death was that it results in the death of. It says, "There is potential for causing moderate to severe harm." Whereas the definitions in Appendix 2 seemed to relate to the 'actual' harm that was caused. I think if you were taking the asterisked definitions it is clear, but actually the grade of patient safety incident is not. I do not know if I have made that point of view clear.

The Vice-President: Perhaps you could take it up with the Director of Fitness to Practise after the meeting. Can I take you to recommendations? (i) agreed? **(Agreed)** (ii) agreed? **(Agreed)** (iii) agreed? **(Agreed)** (iv) agreed? **(Agreed)**. I will hand back to the President.

[Council agreed (i) that single dispensing errors which were not likely to amount to professional misconduct should not be referred to the Society's Investigating Committee; (ii) that the criteria set out in section 4 of the paper should be used to decide whether a single dispensing error was likely to amount to professional misconduct; (iii) that cases which were not referred should be disposed of by way of a letter sent to the individual by the office as a result of the findings of the Inspector's investigations, where the individual admits the allegations made and accepts the advice provided. Records should be maintained to show that the individual has admitted to the allegations made and accepted the advice provided; and (iv) that cases that were not referred should be audited and the criteria for assessing whether a single dispensing error is likely to amount to professional misconduct reviewed accordingly.]

10(a) Code of Ethics Review

The President: We are now going to item 10, which is about the Code of Ethics review. I am absolutely delighted to see this item on the agenda, because some time ago we initiated the work here at the Society to look at a value-based code of ethics. We asked Professor Sheila McLean to chair the group. The paper that you have is as a result of the work in the background. I am delighted to see a team here that contributed to the work.

Can I briefly introduce Sheila McLean? She is director of the Institute of Law and Ethics and Medicine at the University of Glasgow and the first holder of the International Bar Association Chair of Law & Ethics of Glasgow University and is Director of the Institute of Law & Ethics in Medicine at Glasgow University. Most of you know Sheila from the presentations here and at BPC. Over to you.

Professor Sheila Mclean, Chairman, Law & Ethics Working Group: Thank you for giving me the opportunity of coming back. This is obviously the final stages of the working group. As you will see, you know before we have done consultations in the past and the final consultation is described here. We had a good response and I am delighted to say that we had a positive response from people who by and large have endorsed the principles and values the working party described with your assistance over the last few meetings. The best news in some ways is that people felt the code was very clear and hopefully it would be easy, with the supporting documents, for people to put into practice.

In the final consultation you will know we had one or two commentaries in the earlier consultation stages which we have tried to take account of as well as feedback from yourselves. There were not any fundamental changes proposed in the last consultation and nobody suggested we should change any of the fundamental principles that are part of the Code. There were a couple of issues that had

been raised before. You will see from the revised version that we have taken account of both of these. For example, in terms of the question of who amounts to a patient. I think it was someone at this meeting last time I was here who pointed to the fact that some of you were working in the veterinary group world, and we have taken account of that in our description of who a person is for the purposes of the practice of pharmacy. Hopefully that solves that problem. I think we managed to deal with any of the major issues that were raised with us following the final consultation.

This is what happens next. Not that I would know! But the revised Code, assuming that we are happy with it today, will go to the AGM in May. Everyone will receive a copy within a couple of months of that. The Code itself will be launched I think on 1 August. As you see, very importantly there will be a number of support and back up information documents that will be provided to people, so that they can contextualise the Code for professional practice.

For today's purposes, we are hoping you will agree the revised Code of Ethics for Pharmacists and Pharmacy Technicians today. Thank you.

The President: Are there any questions or comments? **(None)** An excellent job, Sheila. You have silenced everybody. Come back again! Congratulations, Sheila, for chairing this very important piece of work for us. I wanted to ask you a question. We have moved from a situation where we had everything clearly written and we knew what is right and wrong, to an area where we have now to interpret the situation and decide what is right and wrong, in the context of what our peers will think about the action that we take. Do you know of any other profession that has made a similar change? And what can we learn, in terms of introducing this code from them?

Professor Sheila McLean: Mandie probably will know better than me, from our days on the UKCC together. I would have thought nursing would be a fairly obvious example of a profession where, once it began to accumulate the final (rules?) was put in the same position as you are in, to ensure that the professional practice was at the highest possible standard. Mandie, you might want to say something about this, but I think it was done very much in the way you have approached this particular situation.

The President: I am particularly interested in what happens from August onwards, because pharmacists would need a bit of help. They are so used to seeing things in black and white, and now grey areas will appear. We will need to make sure there are adequate support mechanisms to deal with that situation.

Ms Mandie Lavin: We anticipate a rising number of calls to the advisory service which may indeed rise further, as people get to grips with the new approach. Professor McLean is absolutely right. Nursing made the shift as did midwifery. I think that as you become a more empowered profession than you are now ... **(Inaudible)**

Professor Sheila McLean: One of the things which is tremendously important will be the outcome of the education review. Obviously one of the ways in which you can support people is by continuing to support them educationally as they develop professionally. I think that will be an interesting review.

The President: That is a more long term goal. Support from the office I think would also be available. I wanted to ensure, because we are in public business, that those people who need to contact the office are able to do so.

Secretary & Registrar: I think that is right. Training and CPD are going to be really important. Some time ago, CPPE (because it was when I was there) developed a programme which would help. It was a number of years ago and it will need revisiting. It is important there is training and I am sure Lynsey probably has a programme plan.

Mrs Lynsey Cleland (formerly Balmer), Head of Professional Ethics: Just to reassure Council there is a lot of work underway attached to implementation. We are looking at various CPD articles for the Journal and looking at questions, case studies. We will be visiting branches and looking at other ways in which we can get the message out to the profession.

Professor Bob Michell: Just to remind Council the excellent example of a profession that went from

a very detailed and prescriptive code of conduct to one based on broad principles, such as we are now encountering was the veterinary profession. The reason I suggested Jane Hern should be a member of the working group was not to represent the veterinary interest, but precisely because she presided over both the reform and its implementation. If the experience of the pharmacists mirrors that of the veterinary surgeons, there will be an initial flourish of skirmishes, for which you will need to be well equipped to handle. It will then rapidly subside. If there are problems, she is only 400 yards across the bridge and will have plenty of experience to offer.

The President: Before we close the item, I wanted to say thank you to the team that worked under Sheila's leadership. Lynsey, would you identify your team?

Mrs Lynsey Cleland: There has been help from obviously the rest of the working group, but a number of Society staff, including the Chief inspector, the legal adviser and obviously David and Ann have been closely involved in the work as well.

The President: To you, Sheila, and the team who supported you, congratulations on an important piece of work. Thank you for helping us out.

[Council agreed the revised Code of Ethics for Pharmacists and Pharmacy Technicians as set out at 07.03/C/18.]

10(c) Consideration of matters arising as a result of the commencement of health jurisdiction under the Pharmacists and Pharmacy Technician Order 2007

The President: Can we go to item (c), consideration of matters arising as a result of commencement of health jurisdiction under the Pharmacy and Pharmacy Technicians Order.

Mr Douglas Simpson: President, harking back to the last item but one, a cold chisel did fall on someone's head as they were walking into 17 Bloomsbury Square (the Society's old headquarters). It did not actually miss and the consequences really were quite severe. So some errors can have dire consequences!

Now the Society has health jurisdiction as a result of the section 60 order, previously there was no machinery for taking into account pharmacists who, for reasons of health, might not be able to practise appropriately. That is one consideration. The other is to do with driving convictions. We took Counsel's advice on these after the Law & Ethics Committee looked at them. It was proposed in general, so far as drink-drive convictions are concerned, that they are considered by the Investigating Committee and that medical reports are only obtained where they received a second drink-drive conviction within a three year period. So in general, all drink-drive convictions are considered by the Investigating Committee and medical reports only obtained where the registrant receives a second drink-drive conviction within a three-year period, after having Counsel's advice. The other area we looked at was Statutory Committee cases where there had been a health issue, but because there was no jurisdiction over health issues the Statutory Committee could not deal with it, and had to deal with it by way of conduct and convictions. The question was: What should be done about these issues thought still to be live, and whether we should look back at those and bring them forward again as there is now jurisdiction over health matters. Having taken Counsel's advice, the Law & Ethics Committee looked at it. Legal advice was taken and as a result of that, it is proposed that these cases are reviewed, and where there is continuing concern, up-to-date medical evidence should be sought about the registrant's health. So not all cases will be resurrected; only those where there is continued concern, and in those cases medical evidence will be sought about the registrant's health. That is the recommendation to Council, having taken legal advice, following the Law & Ethics Committee considering the matter.

Mr Martin Astbury: I am totally in support. Just to ensure everyone got the amended copy of the drink-driving one that was out in the file. It is covering the same thing, but it was an amended version.

Professor Bob Michell: Through you, President, did you consider drug-driving convictions, which are increasing, or would the pharmacist be caught out by not so much the driving, but the fact they took the drug?

Mr Douglas Simpson: I think it is drink that was considered.

Ms Mandie Lavin: We have not looked at just drink-driving in the paper. I think this falls into the bucket of other FTP policy type issues we may need to look at. We had three convictions I can think of relating to driving under the influence of drugs (as well as drink in one case). It is another area we certainly need to explore. It is not in the current paper though. It is more business for Law & Ethics or whatever FTP policy process emerges.

The President: We will ask the chair of Law & Ethics to look at that. Any other questions or comments? With that, can we agree (i)? **(Agreed)** (ii)? **(Agreed)** (iii)? **(Agreed)**
I understand coffee is ready.

Secretary & Registrar: There is (b) to be considered. This is the reconsideration of cases already heard by the Statutory Committee. It is fairly straightforward and perhaps Council can agree (i), (ii) and (iii) under (b). **(Agreed)**

[Council agreed (i) A conviction for drink-driving should normally be referred to the Investigating Committee, unless, exceptionally, a referral to the Health Committee or Disciplinary Committee is justified on grounds of urgency or the making of an Interim Order needs to be considered, or is required because a custodial or suspended custodial sentence was imposed, and, secondly, in the unlikely event of a referral not being permitted under the Rules due to the conviction being more than 5 years old. (ii) For a first drink-driving conviction or where more than 3 years have elapsed since a previous drink-driving conviction, the Registrar should not, save in exceptional circumstances, obtain a medical report from an appointed medical assessor before referring it to the Investigating Committee; it will be for the Investigating Committee to consider the information presented to them to determine whether a medical report needs to be commissioned. (iii) If the registrant receives a second drink-driving conviction within 3 years, the Registrar should normally obtain a medical report from an appointed medical assessor before the case is referred to the Investigating Committee, but this is entirely a matter for the discretion of the Registrar in the exceptional case where a referral direct to the Health or Disciplinary Committee is justified or required. (iv) Cases originally heard by the Statutory Committee where health was raised as a concern should be reviewed and risk assessed. (v) The Society should write to the individuals concerned in order to enable an assessment to be made of the current health situation. (v) A report of the health element of the case should be sent to the Investigation Committee for consideration. This report should be supported by a medical report provided by a Medical Assessor or other appropriate medical practitioner approved by the Society.]

(After the break)

11. Branch Representatives Meeting: motions

We have produced the item. We have David Carter.

Mr David Carter: This paper is to note the motions going forward for debate at the next Branch Representatives Meeting on 17 May and to agree circulation of the draft background information from Council to assist debate on the motions. There are 11 motions attached in the paper and preceded by a blank tracking paper, tracking the reports.

So to note the motion going forward and to agree the circulation to branches of the background information to the motions. I am not sure if you want to go through each one, or whether we should note them as a matter of report.

The President: Let us go through each of them, so if there are problems we take them now and see if anyone has comments.

Mr David Carter: The first motion, which is on page 3/13: **“It is the opinion of this meeting that the Society should relinquish its regulatory role.”** As you can see, under the background information, which is incidentally the same for the first three, it says: “Since the motion was raised, the Government has produced a White Paper.” Motion (b): **“It is the opinion of this meeting that the Society should, in line with other professions, change the name of the Society to the College of Pharmacists.”** Again it is similar background information to the first.

Professor Stephen Denyer: I would suggest that the background information -- this is background information for us, is it?

The President: To go to the Branch Reps.

Professor Stephen Denyer: Can I suggest that we might make an observation about pharmacy now working as a pharmacy team. I am sure colleagues know already my views about pharmacists and pharmacy technicians, but I think we should leave the pharmacy team element clearly stated in the background.

Secretary & Registrar: Can I support that, because we are into team regulation. We and the dentists are special, in that team regulation applies in our case.

Professor Stephen Denyer: And team leadership, I would suggest, which is where the College of Pharmacists probably comes from.

The President: Yes, but team regulation will go to the GPC and not the Royal College.

Professor Stephen Denyer: My particular point was with regard to the reference about changing the Society to the College of Pharmacists. I like the commentary about the background and the White Paper. It is appropriate, but we have made no determinations yet about pharmacists or pharmacy. I think we need make the observation, however, that there is a pharmacy team now in place, and this may well need to be reflected in the future in some form or other.

The President: I think we need to set the context, that the Council has not made any decision regarding the membership in the future. Currently the dental and pharmacy regulation is team regulation. I think what is happening now is that from the branch reps' motions, we are now going to debate something which is raising quite a bit of concern. So what I would suggest is that rather than have a long debate on this particular issue, because this issue will be debated some time hopefully before the AGM, if not soon after. So if we can accept that we will give a balanced view about the current situation, regarding current regulation and that is separate from the membership issue.

Professor Stephen Denyer: That is good.

The Vice-President: Can I speak to this? I attended the East Met Meeting at the branch on 20th February of this year after a Carter Working Party meeting. I made a presentation to the East Metropolitan Branch where, at the end of the meeting, they presented these motions to the branch. I was staggered to see this, knowing what I knew that the following day the White Paper was going to be released in the context. I was able to be silent on this, but I was very impressed with the branch and their recommendation. There were about 80 people there that night. I would say if as a group they were talking of pharmacists; they were not talking about the pharmacy team. I know they are all pharmacists that go to the local branch, but they are members of the Society. I would say there was very little dissent. In fact, there were maybe one or two technical objections raised by members of the branch. There must have been about three or four individuals, who spoke against this particular motion, but it was not on the basis that they were talking about the pharmacy team. So in fact the meeting was very positive to proposals. Frankly I was staggered that they had actually given consideration to this item.

The President: I think we are now moving into discussing the motion here, before it has been debated by the branch reps. This is factual, so we can put this in the background. We are considering three categories of membership, (associate, affiliate member and in addition to that we shall look at affiliate body). All this is being considered at the present time and hopefully if something happens before the branch reps will be able to update the meeting at that time. Can we please not debate the issue before the branch reps have had a chance to debate it? If we want a debate, let us put it on the agenda, but I think this is the wrong place to discuss it.

Secretary & Registrar: I think you are right. We should not be debating these here. We are looking at the contents of the background note, and that note should be restricted to fact and not speculating on what policy might be.

Mr David Carter: Just a bit of balance. When Stephen made his comments the Secretary & Register

welcomed his comments. We do regulate the pharmacy team, but we are reminding people that the members of the Society are pharmacists. You have to have that balance. That needs to be said as well.

Ms Marcia Saunders: What Stephen was adding was a matter of fact.

Professor Stephen Denyer: I apologise, because I will be saying things about other motions. It is not to trigger a debate, but to make sure the background has some further factual elements to it, which might help the debate in the future and this is one. I think you expressed it very well earlier on, Hemant, where you talked about the team of dentistry, regulation of the dental team and the pharmacy team. It is an appropriate thing to put in here, because it contextualises the background.

Mr Douglas Simpson: It is very political what Stephen is saying. We all know that. The Society's policy, as Ann said, is what should be reflected in the response here. Stephen is moving us into another area with a possibility of having technicians as members of the Society. This kind of area, where we have not debated it or changed policy, so we should stick to existing Council policy on the explanations.

The President: Would the Council accept that we will state current policy and no more? **(Agreed)**

Mr David Carter: Item (c). **"It is the opinion of this meeting that the RPSGB assets should be preserved for the benefit of professional members in the event that a complete split of professional and regulatory functions be required."** The background information is almost exactly the same as the previous two. Item (d): **"It is the opinion of this meeting that the Society should develop specific training programmes and guidance, for tutors to support their working of supervising pre-registration pharmacists."**

Mr Graham Phillips: A process. Items (d), (i) and (j) all relate to education. It seems to me that it would be logical, where motions brought relate to particular areas or interest within the Society, those members of Council involved, if it was Practice it would go I assume to the Board now. But this background is produced without any recourse to those committees, or the Chairs of those Committees. It seems to me not the logical process, why not get the value of those Committees and involve those Council members in formulating the background. I would like to see this beefed up. There could be a better process, that we get a greater value by involving the expertise of both staff and members of Council in producing the background.

The President: I do not want to look back. I want to look ahead.

Mr Graham Phillips: I am asking for a different process going forward, President.

The President: In future, how would you like to see the process operate?

Secretary & Registrar: We have an agreed process, the Council has agreed a very clear process for dealing with these motions. Once the motions have been debated, they will go back to the Committees for consideration. The comment here is purely factual which is what it should be. If we want to change that process then we need to bring that to you at future meeting so that you can, if you want to, and refer all these to Committees before they get debated. I think we must remember these are the branches' motions and they should be debated. All that we need here is fact, and the Council members have always had an opportunity to comment on these factual statements which are made to help the branch and the debate that happens at the AGM. We could not put a comment from Committees into it. It has never been the practice to do that. If you wish to do it, you change the process that we have, which has been thoroughly revised fairly recently. There is no reason why we cannot revise it again, but that is the process.

The President: We will take that up away from here. The Vice-President has suggested we deal with that. Can we go to item (j)?

Mr David Carter: **"It is the opinion of this meeting that the Council should advise MHRA and pharmaceutical manufacturers that they should attempt to ensure that all medicines**

containing the same amount, the same active ingredient should have identical or extremely similar organoleptic properties by 2012.”

Professor Stephen Denyer: From a factual point of view, we ought to recognise the EMEA’s role in this, rather than simply concentrate on MHRA. These are now European-wide regulatory aspects, so we should cite that. I do like this approach to providing factual information for background which allows further debate. I think we over-complicate it, if we go do more than that.

The President: There is one thing I would like to see however. I would like to see that where Council agrees with the motion, we should state that clearly, because it could save time. We have an opportunity to agree or disagree with the motion, because some are straightforward, asking us to do specific work.

Professor Stephen Denyer: President, I do not want to disagree strongly, but I think if we align ourselves to a motion a motion, it might actually upset and perturb the debate that should properly happen with regard to that motion. There are others who may want to be involved in the debate, not necessarily members of Council. Perhaps we are wise just to give the factual background and have our own views.

The President: Item (f).2.

Mr David Carter: “It is the opinion of this meeting that when a pharmacist makes an emergency supply, the patient details of supply should be sent to the patient’s GP without delay.”

The President: We are not debating the motion.

The Vice-President: I think we need to highlight the issue of confidentiality, President.

The President: I think the response is a good one. Can we go to item (g) from Nottingham Branch?

Mr David Carter: “It is the opinion of this meeting that the changes in this edition’s page included at the front of the MEP A guide for Pharmacists, should be more explicit and helpful in identifying what has changed, particularly in regard to what the previous edition stated.”

Professor Stephen Denyer: I was going suggest adding that, but also paragraph 2 in the background; could its tone be changed slightly? It reads patronisingly, or ‘could’ be read that way. I wonder if the tone could be more general.

The President: I am sure it could be.

Mr David Thomson: Going back to (f) and the explanation it might be useful to include reference to the urgent supply of repeat medication in Scotland, which has largely superseded emergency supply which requires that the GP to be informed of the supply.

The President: Thank you for highlighting that.

Mr David Carter: (h) from the Southwest Metropolitan Branch: “It is the opinion of this meeting that the Royal Pharmaceutical Society of Great Britain works with the MHRA and other appropriate bodies to ensure that an accurate representation of the shape, colour, size and any markings on tablets or capsules should be printed on the outside of the pack.” There is background information below.

The Vice-President: I do not know whether information from the MPSA might be helpful as background information.

The President: This is an example of an area where action can be commenced even before the motion is debated. That was the point I was trying to make earlier: waiting for the debate to take place and then taking action, when clearly it is a straightforward and desirable thing. Item (i).

Mr David Carter: The first motion from the BPSA: **“It is the opinion of this meeting that there should be a special interest group to represent pre-registration tutors.”**

The Chairman: We are not debating the issues.

Mr Sid Dajani: Surely it would be under the Board's remit. For example, the Boards for each country, because obviously this seeks contributing towards the Boards, and there is a big discussion around how the Boards take into account special interest groups.

The President: It could be one of the points picked up.

Secretary & Registrar: Can David answer that?

Mr David Pruce, Director of Practice & Quality Improvement: Special interest groups can refer matters for report, but they are not under control of the Board. It is important that we recognise the special interest groups do not fall under the remit of the board. The Board would deal with them.

The President: Chairman of Education?

Mr Graham Phillips: There is a common theme between (d) and (i), if you think about it. I think there is significant element of the background missing, which is that we in the middle of a roots and branch review of education. It may be that the result of that is that the basis of the pre-registration year is changed. I do not know. I have views on it. What we have not really said here, we have kind of -- “Well, this is how the world is.” The bit we have missed is that we are looking at the whole of education on a very serious and fundamental basis. We have agreed the principles of education, which are going to come up later, and the BPC will be intimately involved in the process. I think that is very helpful background which is not painted here. It shows that we are thinking of it very seriously and are not just tinkering round the edges. We are looking in a very fundamental way. That is missing and the BPSA and other stakeholders will be involved in the process.

The Vice-President: As a pre-registration tutor, I think it is an interesting proposition put by the BPSA. I think it would be useful if the Society were to consider in the background information facilitating a meeting of pre-registration tutors to ask what they think.

Secretary & Registrar: President, the whole purpose of this -- --

The President: Council, please, focus your mind on only providing additional information. This is important to people who are putting the motion together and want to put their ideas to the whole profession. Please concentrate on the background information so we can complete business in time.

Mr David Carter: The second one from the BPSA: **“It is the opinion of this meeting that pharmacy students should have a comprehensive pharmacy charter to adhere to as undergraduates modelled on charters of other healthcare professional.”**

Professor Stephen Denyer: I think the background should include mention of the White Paper, because the White Paper does indicate that as a prospective future.

Ms Marcia Saunders: I think the background should include reference to the recent review of the Code of Ethics. They have called attention to it. We have a chance to consolidate that by mentioning it in the background.

Mr Graham Phillips: Again, I would repeat the comments I made to the previous motion. Also we had a wish within Section 60 to achieve that. It was denied, but our ambition remains. It is work in process. It is not that we have not attempted to do it, but we have been denied the opportunity.

Dr Sue Ambler, Acting Director of Education & Registration: We are working with CHRE on this issue ... **(Inaudible)**

Mr John Gentle: My understanding was that the reference Sheila referred to about pre-registration students or pre-registration graduates and not pharmacy undergraduate students, which is what this refers to. I do not think it is entirely appropriate that students have the same code of ethics or the same charter as pre-registration.

Ms Marcia Saunders: I was not suggesting any such thing. I was simply saying that they have referred to something that may mirror our Code of Ethics. It is an opportunity to mention our Code of Ethics.

Professor Stephen Denyer: I know you will not like me, President.

The President: That is impossible!

Professor Stephen Denyer: Thank you. It was just motion (B). I wanted to check that factually we would include reference to the fact that under regulation dental teams and pharmacy teams are now under consideration.

The President: That is factual and is our policy now, so that would be included.

Mr Martin Astbury: There are plenty of other factual things I am sure that people could include. I am mindful not to include that. There is already a background there which has lots of other facts in it which are sufficient. I am worried that will open a can of worms. I will be happy to submit something else that factual, which might state that technicians would not be part of any Royal College!

Secretary & Registrar: This may be one can that the Branch Representatives Meeting would love to open.

Professor Stephen Denyer: Agreed.

Mr Martin Astbury: The words are there. Let Council agree the words.

The President: If you want anything else added to it, please let us have it. Would the Council be happy for me to have oversight, because at present there is no wording available. I, working with David, will ensure that what goes to the members is actually balanced.

Going through this exercise has given me a thought that it may be possible to simplify the process in the future. If the motions and background information is circulated to the Council members by email first, so that any additional points are sent to the office, then what is presented to the Council might mean that we take all the views on board. Would that be acceptable to the Council? **(Agreed)**

Secretary & Registrar: President, this particular item, in my experience, always takes a long time.

The President: But not in the future, Ann!! **(Laughter)**

[Council noted (i) the motions going forward for debate at the BRM, and agreed (ii) the circulation to branches of the background information to motions as amended.]

14. Referral to Practice Committee: Pseudoephedrine and Ephedrine proposals.

Can we now go to item 14? I know there is item 12 and 13 to go, but I want to take this item first before we see other items taken.

This item has created quite a bit of debate. Attached to your bundle is C/24, which is a paper produced by the office. Can I ask you to introduce the paper?

Mr David Pruce: This paper is looking at a consultation from the MHRA about restricting availability of medicines containing pseudoephedrine and ephedrine by change of legal status from Pharmacy to Prescription-only Medicines, together with restriction in pack size. It was debated at Practice Committee and the recommendation of Practice was to oppose the proposal. To put it in context, the proposal has been brought forward by MHRA because it is known that pseudoephedrine can be

converted into methylamphetamine in a not too difficult process. I am not sure of the exact process and we probably would not wish to advertise it.

Mr John Gentle: Google will get it for you!

Mr David Pruce: We are presented with four options from the MHRA. The option that they prefer I think is the one that moves Pseudoephedrine, and Ephedrine containing products to prescription-only. The argument we are making is that there are sufficient methods to control these products in this country by retaining the Pharmacy Only status, and tightening control through pharmacy, limiting maximum pack size to 720mg total pseudoephedrine or ephedrine and restricting the sales to one pack per purchase. The view of Practice is this would provide the patient safety and public safety, without necessitating the products going back to prescription-only. Practice were concerned that a move from P to POM would result in an increase in the number of patients going to see their GP rather than buying products over the counter. And that flies in the face of current Government position and the drift of the public taking more responsibility for their own conditions. So the recommendation of Practice is (i) to oppose the proposal to reclassify all pseudoephedrine and ephedrine containing medicines from P to POM and to agree to control the potential of widespread abuse by retaining the P status and tightening control, as laid out on the screen.

Mr Sid Dajani: As David said, this was discussed widely and broadly within the Committee. We had inspectors there and also a presentation from PAGB. What was interesting about this, more so than other concerns raised, is that it will inhibit patient choice in terms of self-care. This would actually have had an effect to general practitioners. We did not see evidence to suggest this was so widespread. It is understandable that potent medicines could become potent drugs, but there is no widespread evidence to say this, more than others, could be detrimental by keeping it as a P. The other aspect was with regard to the amount of complications if it ever became common practice to revert from P to POM. Not only that, but there are lots of medication available that contain Pseudoephedrine as well. So it would not just be removing those packs off; it will be removing a lot of supplies off. Taking all that into account, we realise there is a public protection issue, but there will be more disadvantage by reversal to POM. Whilst we need to maintain public confidence, we need to restrict sales in a more controlled manner.

The President: Any action taken by Government should be proportionate to the problem which exists. It is a gross overreaction to the actual size of the problem.

Mr Sid Dajani: Well said, President.

The Vice-President: Proportionality is a very important issue here. I am sure the 10 lay members of Council at some point in their history have walked into a pharmacy and bought a packet of medicine that contained Pseudoephedrine and found it very useful to use. What we would be doing is denying access, which I think would be against the wider public interest, because if patients are not going to receive access to medicines they need -- and they are arguing in the paper that phenylephrine would do. I would argue it probably would not be so effective. If you look at the paper, the consultation letter, MLX337, the argument under 10 is speculative. It says: "Although the prevalence of misuse of methylamphetamine is comparatively low in the UK, its use and availability is thought to be increasing. If [it] did secure a hold in the UK, the consequences would undoubtedly be very serious." You could argue that even if somebody walked into a hundred or a thousand pharmacies and received 720mg of pseudoephedrine by those means, and pharmacists sold one packet to one individual who went to a hundred or a thousand pharmacies, you still would not have a huge base of pseudoephedrine to do anything with. I suppose the Home Office are attempting to stem the tide of illicit drugs to reach circulation. But in fact, they are not paying the attention they should to the public need. I would think it is like locking up the contents of Wembley Stadium on Cup Final Day, because they are perhaps 100 villains amongst them. That way, you have actually removed 100 villains from circulation and put them 'all' in prison. It is almost barmy. I do not like to say that, being Vice-President, but proportionality has to come into the thinking.

If we can put into place effective measures to restrict the way this drug is supplied to the public, through the methods we have in place currently (through our M E P) in the way we restrict the sale of codeine linctus, it would make good sense. I think it is common sense that needs to prevail in the

supply of medicines and not overreaction because of problems that are fast growing elsewhere in the world. For instance, in America they do not have the ability to restrict the sale of a P medicine. I think it is not comparing like with like. I think we should oppose this. It is not fair to the public interest, and I think we should think of the public interest.

Mr David Carter: Gerald has said what I wanted to say. It is just to remind everybody that the problem appears to be in the US, and I think there is no P category medicine. It may be appropriate there, but here we have the P category as a safety net.

Mr John Gentle: Along with Gerald, I am sceptical of how many manufacturers of crystal meth are going to come into my pharmacy and try to buy a wheelbarrow full of packs of Sudofed, because that is what they would need to get anything from of it. Expensive as well as impractical. I do not think this measure will achieve what it is set out to do. Further than that, at the PSNC conference last week, the delegates came out strongly opposing the move from P to POM. At a couple of branch talks I have done, the members oppose it. The only change I would make is to add 'strongly', so we 'strongly oppose' the proposal. There is a depth feeling in the profession that it is almost a professional insult to us. Members, pharmacists around country, do not want this happen. We want to make it clear that we back them and strongly oppose this measure.

The President: Whilst I think the pharmacist's voice is an important, we should also get our lay members to express their views here. I know there are three or four wanting to speak. But I think just to balance it, this is not about a commercial interest; this is a professional issue, which we are dealing with in a responsible way.

Mr Paul Bennett, Chairman of English Pharmacy Board: I think the Vice-President and John Gentle articulated well the strength of feeling the profession seems to have about this. I wanted to make three points. One is that proportionality is absolutely the thing that needs to be at the forefront of minds, and this is a disproportion response. It is worth focussing on the Oregon experience, which I think is the only state in the USA where they have moved this into the POM category. When we challenged the MHRA they are unable to give you the results of the experience of moving it into a POM category and the affect that has been crystal meth production. The other point is I understand that SOCO, the Serious Crime Organisation are very concerned that a move to POM is very much the wrong thing to do, because they are concerned that serious criminals will become engaged in this activity and it will drive it very much underground. So we have to bear in mind the public interest from that point as well.

Dr Brian Curwain: We need to oppose this, but we need to have had a full debate about all the issues. It is not actually like controlling codeine linctus. What people do they are making crystal meth is they cook it up with solvents and so on and so forth, and a lot people uninvolved with drug-taking get harmed. I take the point Paul made, that this is not going to be an effective measure. I know the chief police officers have the ear of the Home Secretary very strongly on this, and I suspect that we may not win the day. I have been involved with Hampshire Police and some of their evidence that they have. For what it is worth, they have discovered a crystal meth factory on the Isle of Wight, so the problem exists. We just need to be clear. The point about this not being commercial but is about patients needs to be made clear to the people we are talking to.

Mr Jonathan Buisson: This was discussed at Company Chemists Association meeting I went to recently. I would commend David to get in contact with Rob Darracott. He has some interesting background information. In America, the federal response was to introduce what we would recognise as a P category; restricting sales of this product and limiting sales, which was quite effective apparently is reducing the local crystal meth lab problem. All it did was make sure most of the crystal meth gets imported wholesale from Mexico. I understand from that briefing that most of the crystal meth in this country gets imported wholesale from The Netherlands, and the Isle of White lab is the only one the police can put their hands on and say, "Yes, we have the problem and we found it and shut it down."

Ms Marcia Saunders: I just wanted to say this has been such an interesting discussion. This was such a revelation to me because I now understand why when I go to the States young Americans have been asking me to bring them Lemsip! All I can say to you is that we are usually about ten years

behind, so let us do take this very seriously as a need to control and monitor and measure what is happening. I accept the arguments, but it has been a revelation. I could never understand why these young people were so interested in cold remedies!

The President: This is not an invitation for wholesaling!

Mrs Lorna Jacobs: As a lay person, I would ask the views that I express in this issue to be publicly informed by the views of the professional members about how comparable phenylephrine is with ephedrine. Because as a member of the public, that is the first key issue. If you are talking about risk, what is the down side to the patient, I would like to know your professional view of if I am going to have to take phenylephrine instead of pseudoephedrine and ephedrine, what are consequences to the public to treatment of their coughs and colds.

The President: I will give you full written advice.

Mrs Lorna Jacobs: What I think I am saying is that actually, for lay people, without that bit of information, we cannot contribute to the debate of what is the impact on the public.

Mr Graham Phillips: I think you will find that the general professional recommendation for pharmacists is consistently pseudoephedrine based products. You will obviously understand the reasons behind that. That is why we are reluctant to lose it, because it is an important part of our therapeutic armamentarium.

The Vice-President: We also lost phenylpropanolamine a little while back, and that was a very useful drug.

Mr Sid Dajani: I can explain that under two clinical issues. First of all, pseudoephedrine works a bit quicker. Its half-life is a bit longer and the third most important aspect is that it is found in more products (like Lemsip), for the first reason. So if pseudoephedrine becomes a POM, there are a lot of products that are eventually not going to be allowed to be sold.

Mr Alan Kershaw: President, I am glad to hear what Marcia says on the next time she goes to the States, because there are one or two things I get asked to bring back for my family, which are more effective than what we can get here.

Ms Marcia Saunders: Ten percent!

Mr Alan Kershaw: Wearing my daily hat, I did see a police presentation on crystal meth and its effects. I saw the pictures and it is not nice. I respect the people who made the presentation. However, there is a tendency to overreact and to try to pick off every possible risk, when there are gigantic risks. You only have to walk across the river at night to see in the evening the things going on that really bear a need for heavy policies. It is a matter of balancing risks.

I am happy to be guided on the science, but I would commend, not only here, but in all sorts of things we do, the recent report called "Whose risk is it anyway?" by the Better Regulation Commission about balancing risks and the risks you cause by cutting off tiny risks, the much bigger risks you can have. I think what is being said is that the risk of restricting access to these medicines is potentially greater than the risk of not restricting it. I would simply ask, why should any of us fear pharmacists will be less responsible in handing out these drugs than GPs would?

The President: I deliberately allowed this debate, as I think there is widespread interest in the profession and outside. It is important people know the views of Council members.

Mr John Gentle: I agree with what Marcia said in terms of drug abuse, that what is going on in America probably will end up here. I do not doubt we will have a crystal meth problem in the future, but I seriously doubt this would be the source of it.

Could we amend (a) to say "strongly oppose", because there is a degree of feeling within the profession on this? **(Agreed)**

The President: There is a third recommendation I wanted to make. We are a responsible profession and we recognise the potential risks described. I think MHRA should be asked to put this on a watch list, so that if things did develop in the way they fear it will develop, then some appropriate action can be taken. But I think in the meantime, the action should be proportionate to the risk in the UK. So item (i) and (ii) and the third item is that the product should be put on some kind of watch list at the MHRA. Is that agreed? **(Agreed)** So you have accepted (i) (ii) and (iii).

Dr Brian Curwain: One more point about the possible theft of stock, and whether the Society would wish to give advice to pharmacists concerning the stock levels of products like this. Because that is how to get hold of a lot, to smash the pharmacy open and take the whole lot. It is not to buy several packets.

The President: I would like to take that issue away and see what can be done.

[Council agreed (i) to oppose strongly the proposal to reclassify all pseudoephedrine and ephedrine containing medicines from P to POM status; (ii) to propose to control the potential for wide spread misuse via retaining P status and tightening control through pharmacy practices (eg limit maximum pack size to 720mg pseudoephedrine / ephedrine and restrict to one pack per purchase), and (iii) to ask that the MHRA put products containing pseudoephedrine / ephedrine on a watch list so that action could be taken if problems with illegal manufacture of methylamphetamine arose.]

12. Principles of Pharmacy Education consultation

Can I have your attention please? The Council is asked to adopt a revised set of principles and to approve the next steps forward in the Pharmacy Education Programme.

Dr Sue Ambler: The revised principles have been discussed at Education Committee before coming here. We came to you last year with a draft to go out to consultation. The team has subsequently been on the road. We have had extensive meetings with quite a lot of the pharmacy stakeholders right across pharmacy education, including technician education, in a series of meetings in October last year, which went very well. It was an interesting experiment in consultation, not just simply relying on a written consultation, although that was very successful. We had 80 plus responses to the written consultation. Actually, the flavour of the face to face discussion was hugely important in our thinking, but also in building consensus around what could have been quite a difficult and contentious subject for the Society. My first contention here is that we are told that we are not very good at leadership. I beg to differ around this issue. We had lots of very helpful comments in the written and in the meetings. One of the things we are asking is to publish the summary of the consultation response, because following Cabinet Office guidelines we went out to an external reviewer (that was Tony Harrison from The King's Fund) and he was very painstaking in making sure that we did not just do a quantitative analysis; that we did hear the single comments as well and weigh those against the volume comments that we had.

All in all, we experimented with a number of things with the consultation and I would recommend them all to you. One of the things to bear in mind is that it is quite time-consuming for those who go out on the road.

Having got the comments back, we then had stakeholder meetings where we fed back changes we are going to make, and some of the key points that had been drawn out in terms of implementation. Again, that was successful, time-consuming but very worthwhile. The draft, of the final set of principles in Appendix 2 to the paper reflect very much an extensive consultation, and I recommend those to you for your adoption.

The way in which these will be used by the Education Committee and the team internally will be to guide the second phase of our work, which is about to begin. We are going to promote the principles, because the aim is that everybody who is involved in education will use those to guide their own work. They are not the standards of the regulator; that is what we are working on next. These are very much a set of principles that anybody involved in education should have at their side when they are revising their own guidelines and quality assurance processes. It is a contribution to a wider debate that the Society is making here. So they are not standards as such; we are moving on to those next.

I guess it is worth drawing your attention to the four broad over-arching topics that came out, because they are quite interesting in the current debate about clinical practice and the whole essence of conduct.

There was very little antagonism towards this and in fact a lot of support; that the main aim of education is to develop professional ability; regardless of whether the pharmacist is going to practice (whether industry, academia community or hospital). The same things stay with the profession and the reason for doing the degree and the pre-registration is still a level of professionalism. But that professionalism when defined in pharmacy is about being patient-centered and medicines focussed. Wherever we went, it was "Don't drop the medicines focus," which was something we were not having any intention of doing. It is not just about medicines "and to hell with the patients"; It is not swinging too far the other way; that it is all about communication skills "and drop the knowledge" is equally valid, and we have picked that up. Also there was a strong sense that we needed to get our act together and integrate much more carefully, either physically but certainly intellectually; the process that students and trainees go through and through into CPD the standards of education, and that is what we will be doing in the next phase.

The one sense where we did have to do a lot of explaining was back to the term 'proportionality'. There was a sense that some of the things that we were proposing, particularly around selection, where you were selecting undergraduates at the start of their year, but if you were running a CPD programme -- "get off my case." We have tried to explain that in terms of proportionality; that you are mindful of it, in one sense, and you have very careful selection process for another.

With that background, if there are questions I am happy to take them. Otherwise, ask Council to adopt the principles and agree to publish the consultation results on the website and to note the next steps going forward.

The President: Are there any questions on principles of pharmacy education?

Mr Sid Dajani: I absolutely agree with the principles, but I am trying to work out a way in which I want to see that the principles encompassed here will mean that pharmacists will be able to do calculations before they do their degree and are tested on it, than during their pre-registration year.

Dr Sue Ambler: That is a bit detailed for a principle, but it would be part of the selection; that people would automatically be screened about the A levels they do.

Mr Sid Dajani: You know my angst on this.

Dr Sue Ambler: I do, Sid, of old!

Mr Sid Dajani: If they get a degree and fail the calculations in their pre-registration year, how good is our degree? If they are not good enough to pass the pre-registration, how good is our degree? I always worry that the pre-registration exam is always going to undermine the degree.

The degree should be about knowledge, philosophical outcomes and more importantly about specialist care. Practice, Science, Academia. Pre-registration should be about the practice they are in. Therefore the pre-registration exam I think undermines a lot of these principles, because these should be incorporated in the undergraduate courses before they do the degree. I wonder whether these principles will ensure that that is the way forward, and we are not going to keep fudging the issue around the pre-registration exam.

Dr Sue Ambler: The detail of the standards will be at the next stage. That is when we will have the opportunity. Certainly from the practice framework, in terms of defining capability, I cannot imagine for one moment that we are going to drop calculation at the point of registration.

Mr Sid Dajani: We want it at the point of the degree. That is my point. It is too late if people fail during their pre-registration year. It means the job is not being done in the undergraduate level. I will not be here next time, so I want to make that point. **(Laughter)**

Dr Rose Marie Parr, Chairman of Scottish Pharmacy Board: One comment. There is an issue around providers. The comment is that I think it demonstrates leadership on behalf of the profession on how well the consultation was done. I think it was done very well and very professionally.

Secondly, I think the principles will be very useful for education providers of undergraduate and postgraduate levels, to actually increase the awareness of pharmacy education and hopefully some of the resources around that as well. We will be able to utilise the principles... **(Inaudible)**

Dr Sue Ambler: That is what we would hope, Rose Marie, that people would use it locally to lever money as well as nationally.

Mr John Gentle: In the recommendation 9.1, we are asked to adopt the principles of pharmacy education. The fitness to practise principles, which appear on page 27/47 are a little vague. In general it a bit mother cooking apple pie. There is nothing you could oppose per se. But when talks of preventing "unsuitable students" and how early you apply these principles to them, are we talking about -- I mean, I am 44 now (or I will be tomorrow, so I thought I would get that in!) and I do not think it is right that the same kind of unethical standards for behaviour that is expected of me as a middle aged professional should be applied to an 18 year old boy at college. There is nothing here that tells me what I am agreeing to impose on these boys and girls (because that is what they are) if we pass 9.1.

Dr Sue Ambler: It is in the over-arching theme around proportionality. It is one of the things that you rely on the people who are writing the standards. That is the point at which you would deal with that.

Mr John Gentle: Will it come back to us?

Dr Sue Ambler: Yes. You are only agreeing the basic principles. We would come back to you. If we were to impose the Code of Ethics on a new entrant for School of Pharmacy 1, I suspect Stephen would be down on us like a tonne of bricks (probably before you got there, John.) Also It would have to come back here. That is the next stage; reviewing the standards, which would include the accreditation handbook. And those are the kind of places we would put them. To be honest with you, I think we would first encourage, as one of the motions suggested, the heads of school and the BPSA to come up with a charter, because students' registration is very... **(Inaudible)**

The President: If you can talk us through the next steps, so if there are questions relating to that, we can take them. Then I would like to come to Stephen.

Dr Sue Ambler: The next steps will be looking first at the our own existing standards around M. Pharm and the pre-registration, so that is the pre-registration exam syllabus, the pre-registration programme and the M. Pharm indicative syllabus and the accreditation handbook. Instead of doing each one on its own, we are going to tie resources in team committing to do them as one piece, so if nothing else, we integrate the standards intellectually. That may address your point, Sid, but I am not making any promises.

We will then look at making sure the assessment, as it says in the principles, are applied at the right time and the most appropriate point on the spine going forward to registration.

We will continue the dialogue with as many stakeholders as we can going through. But we are not going to sit in a dark room with a damp towel around our head, come out in a year's time and say, "Boo! Here they are!" Damian and Nicola, who are going to lead this work, are quite committed to the proposals around and the tone taken with the consultation. So that would continue with the input of the Education Committee and the Academic Pharmacists Group.

In that process of dialogue we will look carefully at the resources it will take to implement those changes. That will be the point at which we will seriously engage in trying to change the funding streams for pharmacy education, because some of the changes may well have serious resource implications, and it would be hugely irresponsible of us to move one without the other. But until the funding bodies see we are serious about turning out a proper clinical education, they will sit there

going, "Yeah, yeah. Bring it on! Whenever." So we will be trying to progress those in a timely way and hopefully arrive at the end with a proper funding stream, proper structures and a set of standards that we can be very proud of.

Professor Stephen Denyer: I want to commend the effort that has been put into this. It does reflect the seriousness with which the Society regards education, in terms of its provision of future sound practitioners. I think the details we have sought some information of will come later, as Sue describes. My colleagues will be reassured that I can reassure Sid on the calculations at later stage, but I will not do it now!

The Vice-President: Just a point, in terms of the preparation of the agenda, I note from the rest of the agenda that the Chair of Law & Ethics introduced the referrals from the Law & Ethics Committee, but I note that this particular paper (I know it has come through the process of being discussed in December Council and in April 2006), but it has been back to Education. I wonder why the Chair of Education did not introduce this.

Dr Sue Ambler: Because this has been part of a Council policy programme. The Council agreed the programme and agreed the steps in it. What was agreed at the time was that the Education Committee would provide the sounding board of the internal team and would discuss each draft with the Education Committee, but that it was a Council programme. So it was corporate and strategic led.

The President: For the future, it would be useful to involve the relevant chairmen.

Mr Ray Jobling: Sue mentioned leadership. I would like to say really the Society deserves our thanks for leading on something so fundamental. The first steps towards looking at the profession over the next decade. There is lot to be done, but as a set of first steps, it is remarkable. I commend you, starting on page 41, the annexe, which is the advice on the analysis of consultations, where you will see that the Cabinet Office no less has principles for consultation. Would that other parts of the Civil Service understood it!

The President: Can I ask you to adopt the Principles of Pharmacy Education? **(Agreed)** (ii) to agree the publication of the consultation results report and the final version of the Principles document. **(Agreed)**

Mr Graham Phillips: Can I confirm with that there is an analysis which I think Damian did. Is that to be part of it?

Dr Sue Ambler: No. The analysis is also the analysis of the APG consultations Damien did. That will be published as well.

Mr Graham Phillips: I am thinking of Appendix 2.

Dr Sue Ambler: That is the Principles of Pharmacy Education.

Mr Graham Phillips: Would we publish it?

Dr Sue Ambler: We have just adopted it!

The President: Can we go to (iii), to note the next steps forward as described by Sue in the paper. **(Agreed)** Thank you very much for the work done so far, I look forward to a further report in due course.

With that, I would like to go into confidential session which would originally be due to start at 5.15. I think it would be useful to spend a few minutes before that. Can we continue in public business tomorrow? We will begin by looking at the confidential agenda at nine o'clock.

[Council **adopted** (i) the Principles of Pharmacy Education as set out in the paper; **agreed** (ii) that the consultation results report and the final version of the principles document be published, and **noted** (iii) the next steps forward

in the pharmacy education policy programme.]

Presentation of Honorary Fellowship to Vincent Lawton CBE.

Council, colleagues, may I have your attention please. This is one of the pleasant duties that the President has. Professor Lawton, the Society was given power to elect honorary members by virtue of its Royal Charter. We can elect as Honorary Members people who have rendered distinguished service to pharmacy. Only two or three members a year are elected, so Vincent you are joining a very select band this evening.

Vincent you started your career in a management consultancy company, whilst at the same time undertaking study leading to a PhD. You then moved on to publishing, followed by positions in HR before joining Merck Sharpe and Dohme (MSD) in Europe 1980.

With MSD you worked in France, Spain, US and Canada before assuming the roles of MD after MSD UK and Vice-President of MSD Europe. In the 25 years with MSD you held a variety of roles in sales, marketing, human resources, R&D, project planning and general management. As European Vice-President, you were part of MSD's European Management Committee, deciding strategy for the company in Europe. You were also the European representative of a world-wide business strategy team focussing on the Osteoporosis Franchise. You were personally responsible for the launch of more than 15 new products in Canada, Spain and the UK, each of which have attained market leadership. You have made a significant contribution to clinical trials, policy and collaboration and to the furtherance of health sciences. In particular you contributed to developing patient information and choice in collaboration with the Society. This included a key role in supporting the Society's innovative work in understanding patients' attitudes to medicines and medicine taking. The Society initiated studies of concordance in 1995, with the support of a grant from MSD. This work led to the publication in 1997 of "From compliance to concordance, achieving shared roles in medicine taking". Arising from this work, the concept of concordance was included in Government policy. This was expressed in the pharmacy plan "The future of pharmacy, implementing the NHS Plan", published in September 2000.

The Medicines Partnership was established with funding from the Department of Health in 2002. You continued to support this work through board membership of the Medicines Partnership and played an important role in securing the industry's role in Ask about Medicines Week. In 2006 you completed a successful two-year term as President of the Association of the British Pharmaceutical Industry. During this time, links between the Society and the industry were further strengthened when the ABPI became a major sponsor of the British Pharmaceutical Conference, our flagship event. You also initiated the APBI Annual Pharmacy Award, to recognise innovative practice that brings benefits to patients. In 1998 you were awarded an Honorary Professorial Chair by the University of Wales School of Health Science, and in the 2006 New year's Honour List you were awarded a CBE for services to the pharmaceutical industry.

Vincent, it is my great pleasure now to ask you to accept your certificate of Honorary Membership of the Royal Pharmaceutical Society of Great Britain in recognition of your work in the industry generally, and also in partnership with the Society of the innovative work on concordance.

Professor Vincent Lawton: I am always amazed, Hemant, at how slim he has managed to stay during his period as President! I remember my two years as ABPI President, where I was eating for Britain, and we were comparing waistlines as we went through, and he won, hands down -- in the positive sense! But it is for me being not just a pleasure, but I consider it a tremendous privilege to have been able to work so closely with the Society and with pharmacy in general.

It has always struck me since I have been back in England since 1991 that the role of pharmacy in terms of determining patient healthcare, and in terms of prescribing and so forth, was just not being seen by the public sufficiently well. I think the work which Hemant and you as a Council and the Society in general has done in developing the role of pharmacists and pharmacy is just extraordinary. It has come on leaps and bounds over the last few years. And now you take your rightful place, I think, in helping to determine the right approaches, the right medicines for the appropriate patients, which our colleagues, the doctors, are not always fully capable of doing. That has been really nice. You should have heard me 15 years ago, when I first came to England and saw some of the

prescribing errors, which were, thank goodness, saved by some very astute pharmacists who actually saved patients' lives and made sure they got the right medicines, and not combinations of effectively poisons, often prescribed by inexperienced and not very well trained doctors. Clinical pharmacology is not taught to any extent at medicine school, which I think is great shame. It is not examined in any medical school at the moment. But I think this, concomitantly, is the opportunity for pharmacy and pharmacists to really rise into their true position to be leaders in healthcare in every facet of healthcare. I look forward to being associated with that as an Honorary Member and watching your progress and helping in any way I can, because I think it is an extraordinary Society and the work you have done is deserving of great credit. Thank you so much for this terrific honour which you have given me today. I did not recognise half of the very kind words. It was 26 years with the industry. A year between friends is not much and does not seem to be important and does not seem to be a day too long.

The President closed the meeting.