

THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

Transcript of the Public session of the Council meeting held on 12 December 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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PUBLIC BUSINESS

Present

President	Mr H Patel
Vice-President	Mr M Astbury
Treasurer	Mr A Gush
Mr S Acres	Ms S Agha
Mrs M Allan	Mr G Alexander
Mrs C Brown	Mr J Buisson
Mr S Churton	Dr B Curwain
Professor S Denyer	Mrs D Drury
Dr P Entwistle	Mr J Gentle (from item 07/124)
Mr J Hanlon	Mrs S Hikins
Mrs L Jacobs	Mr R Jobling
Mr J Jolley	Mr A Kershaw
Mrs S Kilby	Professor B Michell
Mrs L Morgan	Mr G Phillips
Ms M Saunders	Mr D Simpson
Mr D Thomson	

In attendance

Mr P Jones, Chairman Welsh Pharmacy Board and Mr F Owens, Deputy Chairman, Scottish Pharmacy Board.

Director of Finance & Resources: Mr B Kelly

Mr Hemant Patel, The President: Good morning Council. This morning we have apologies from David Carter and from Jane Ramsey.

We have a lot to catch up, but I want to talk about last night's dinner for four or five minutes. I hope you all enjoyed yourselves last night. From the feedback from our guests, I think they enjoyed the evening. Later on Deborah will give you forms for feedback. So if you can feed your forms back later, I would appreciate that.

In terms of interaction with the Minister, I felt that she was relaxed and happy to chat about all kinds of things. Although she has a wide range of responsibilities, I felt she had an understanding of the pharmacy agenda. Having been there for only a short period of time, if we can help to enhance her understanding of pharmacy issues, she would welcome it. I certainly felt relaxed and enjoyed the evening very much.

A number of things came out from it. One was instead of sending emails and letters, if you want to pick up a phone, pick up a phone, which I thought was a good sign. Secondly, I think she would welcome an opportunity to meet in less than formal surroundings, which is very good.

I had Bernard and Deborah on my table too and it would be interesting to pick up their comments, because we all went with one or two messages we wanted to get across.

Mr Bernard Kelly, Director of Finance & Resources: I think I took my brief well. Deborah gave me two points to make and I made them when the opportunity arose and the Minister seemed very receptive and very relaxed.

The President: Deborah, do you want to give some feedback on your assessment of the evening?

Deborah Oliver, Interim Director of Public Affairs & Communications: I thought that the whole atmosphere was very positive and friendly and the guests I spoke to seemed to be responsive to hearing the messages we were putting across. I think the message I got very much was that people were looking to the Society for leadership and to speak with this strong voice and to give these messages. I thought it reconfirmed that we need to be communicating consistently, but I thoroughly enjoyed it.

The President: We have a number of items which we deferred from yesterday. These items related to 8(a), items under the Law and Ethics Committee.

8(a) Consideration of cases for non-referral to the Investigating Committee, single dispensing errors.

Doug, would you please present the paper and there will be supplementary comments from David or Mandie as appropriate.

Mr Douglas Simpson: I was in Bromley Casualty this morning, if I am not myself, with my father-in-law. We started in March a new initiative on dispensing errors. The problem is that the infringements process is clogged with lots of small misdemeanours and we have to try to unclog it. We started off in March with a new policy of single one-off dispensing errors. The Inspectorate has been operating the non-referral system since June 2007, and 18 cases have been dealt with successfully by the Inspectorate in this way. The average time taken from receipt of a complaint to closure is six to eight weeks. This has a certain power in the system which has been set up for dentists by the BDA. It is not exactly the same. They have a new system for handling complaints which are not appropriate for the full fitness to practise procedure. It is a sort of formal/informal process involving local resolution of complaints. I went to the launch of that system about a year ago, and thought that would be good for us to have. You realise that with our inspectors in a sense we have got the system for informal resolution of complaints. I am a bit slow on the uptake to realise we have in fact a means of dealing with complaints in a systematic way without involving the full fitness to practise process. This is it and we started to operate it. It seems to be operating successfully.

During the course of the operation of it, we found the definition of dispensing errors a little too narrow. The idea is that we should extend the scope of it and consult with the membership and other stakeholders and on the threshold criteria for dispensing errors. The experience so far has been good, on what we have started already. We want to broaden it and we want to consult slightly on a broader definition. That is broadly what we want to propose. I do not know if Mandie wants to add to that. I cannot imagine it will be controversial in the Council.

The President: Are there any comments or questions?

Dr Brian Curwain: There was one thing I managed to clarify with Jackie Giltrow before this meeting about the definition of single dispensing errors, which I was not able to find in the papers. Quite often if you make an error, particularly an error of labelling, it ends up that two things are wrong -- because of the labelling. I was reassured that really it is about a single event rather than a single set of medicines that is wrong. It is helpful that we know that is how they are being directed to interpret it.

Mr Douglas Simpson: I should have made that point clear.

Mr Graham Phillips: We are talking about appendix 1, which is the list. Is that the correct renewed list at page 6/10?

Mr Douglas Simpson: If the error meets one of these, it has to go into the fitness to practise

procedure. If not, it will go through the Inspectorate procedure.

Mr Graham Phillips: I am grateful to Mandie for her help on this. We have had extensive correspondence on this and I am grateful for that. I would like to share with you my thoughts on this. Clearly I am in favour of the direction of travel, but I have some concerns about practicality for some with this. If everyone is appendix 1, it concerns me that we are treating -- and I understand the reasons for it, but when you make a mistake, you cannot arrange for that mistake to be around a benign product. It is equally easy to make a mistake that has serious consequences, in terms of someone's health. Yet the error is the same error. I cannot see the logic, in human terms, to treating error where serious harm could result fundamentally different, because it does not occur in that way. I understand there is the public interest, and so on and so forth, but by treating these errors differently I think the risk is that you will get less recording, less feedback, less openness and it will work in a perverse way. That is my first point.

Bullet point 4, which talks about evidence of having departed from agreed protocols and safe operating procedures. I think this is probably wordsmithing required. Clearly, if you follow the protocols and procedures you will not make the error. Clearly this is a case of behaving negligently, in terms of deviating from safe protocols and failing to follow them. I am sure that is the intention. I feel we need some wordsmithing there.

My final point -- and it is exactly the same one I made when this has come up twice about -- is about the relevant history within the last three years. I fail to see it is appropriate. There is no pharmacist in the land who is dispensing on a regular basis who has not made an error within three years. Where would the relevant history come? It would depend on how busy the pharmacy is. It will depend on the circumstances of the pharmacy. It would depend on the litigious nature of the patient population. I know that from my own group of pharmacies within a discrete area. There are completely different approaches within the different local patient populations to an error. Some say, "You have looked after us for many years. We want an apology about why it occurred and what you are going to do about it." Some of them see it as, "How much money can I get out of this? Why on earth should we subject individual practitioners to a completely unreasonable situation in the first place, because the likelihood of no error within three years is zero, I suggest. Secondly, relevant history derives from all sorts of circumstances completely outwith the individual practitioner's control. I am as firmly opposed to this as I was when it first came up.

Ms Mandie Lavin, Director of Fitness to Practise & Legal Affairs: I have a great deal of sympathy with all the point Mr Phillips has made. I think he is really re-emphasising why it is absolutely essential that we take the project forward and consult. Certainly in terms of the intent of these criteria you are absolutely right, in terms of looking at things like departures from protocols and standards. It is often about the degree of departure, quite often. If someone has been utterly reckless, that is one thing. But I am sure there are moments in all our day-to-day professional practice when we do not utterly adhere to absolutely every single requirement of our position. I am sure we would probably all grind to a halt if we did in many circumstances. It is trying to place that barrier at the point where it is going into what really does become an unacceptable risk to patients. The relevant history within the last three years I think is controversial, and I think the point that has been made, and the dialogue we have had through email about it, has been very interesting. I think it is a matter very much for the profession. We do have research. The Society indeed was part of that research. I think that we are breaking some very important new ground here. I do not think there could be a more important time for the Society to be entering into dialogue with the profession about something that means something to every pharmacist in their day-to-day life. So I cannot counter any of the points that have been made; they are very well made. I hope that this is the sort of feedback we are going to get in the consultation process. I think just to re-emphasise one of the important aspects for us here was, in effect, doing a pilot and putting our toe in the water. Out of the 60 reports it is interesting that only 18 have fallen into that very, very narrow category. I think the point raised earlier about difficulties of things like transposition of labels and the sorts of day-to-day errors -- is it one, is it two, is it four -- is the sort of thing we really need to bottom out. I think this is an important project. I think it is in the profession's interest and in the public interest to really strive to get this right.

The President: Can we go to the recommendation?

Mr John Hanlon: I see John Gentle is not here. He mentioned to me to get an update of Mandie sitting there on how you are getting on trying to decriminalise the dispensing errors.

Ms Mandie Lavin, Director of Fitness to Practise & Legal Affairs: I think we are making good progress. We put together a parliamentary briefing, which has been circulated. We know that we now have on record the support of the National Patient Safety Agency and the Guild of Hospital Pharmacists and a number of other bodies. We have even had dialogue with CHRE about it. I think that they, obviously with an eye to the discharge of our statutory duties I think have recognised the importance for the profession and for the public of us getting this absolutely right. I think we are making good progress and I am happy to report that, President.

The President: What would the next steps be and when?

Ms Mandie Lavin: Next steps in legislation? Clearly we are looking for some amendment of the relevant provisions of the Medicines Act. We are not looking upon them to be deleted; we want them to be amended, because we are not the only body that relies on some of those provisions. We have had some interesting drafting thoughts, but that is probably a matter for lawyers more senior than me.

The President: I have repeatedly asked the same question, When is it going to happen? I know it is out of our control in some ways and subject to a parliamentary timetable. Do you have a rough indication of when things are going to start moving?

Ms Mandie Lavin: I think the whole issue is gathering momentum and getting higher profile. One thing would be through the consultation process to gather together the thoughts of the profession and the public. These papers have been shared with the Patient and Public Involvement Group for their thoughts, and I am sure they will respond to any of those bodies to the consultation process. I think when we have over that overview, getting that synthesis of those views together I think will be very powerful. We are in the hands of the parliamentary timetable and we all know, I am afraid, the uncertainty of that, President.

The President: Council, can we go to recommendation (i)?

Professor Bob Michell: I do not to oppose this, but make one suggestion and comment, in the light of Graham's comments, which I fully understood. The suggestion is that since we do have a list of criteria, with respect to single dispensing error, I think we should consider that an additional criterion should be that the patient is from a vulnerable group. The most obvious example is children, but it is not restricted to children. Why? Because the chances are that the error, or the consequences of the error, will go on for longer before they are actually picked up. An adult is much more likely to spot that something is wrong, or to express the view that what they are experiencing after taking the drug is different to usual or whatever. The comment is on the question that it is the same error. I have great sympathy with that and I understand it, but in general we live with the philosophy that the consequences of error dictate the attitude that we have to the error made. You could argue that a car driver running a red light, a train driver running a red light or a jumbo jet pilot or air traffic controller making a single error, at a psychological level are all the same, but I think they are not. Because in choice of career and in training, we all understand that we take responsibility for errors that have different degrees of consequence. I therefore think that we cannot just say it is the same kind of error. At that level, calculating a dose for a patient wrongly is only the same as calculating the ingredients for a cake wrongly, but it is not the same because of the consequences.

The President: To take your point on board, can we log this in, so it is fed into the consultation exercise with other responses? With that, can we agree (i) (Agreed) (ii)? Agreed (iii)? Agreed. The next item is 8 (b).

[On the recommendation of Law & Ethics Committee **Council agreed** (i) that the scope of a single one-off dispensing error should include errors made during the dispensing process, from receipt of prescription through to supply of the dispensed medicine to the patient; (ii) that 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. Records should be maintained to show that the individual has admitted to the allegations made and accepted the advice provided; (iii) that the membership and other stakeholders should be consulted on the handling of one-off dispensing errors. In the interim period the scope of a one-off dispensing error should be widened.]

8(b) Consideration of other cases for non-referral to the Investigating Committee

Mr Douglas Simpson: My general comments about the last paper applies here to about using the Inspectorate. We have 27 inspectors covering the whole of Great Britain and they are a fantastic resource. An interesting statistics, Jackie Giltrow told me out of 200 cases in this neck of the woods that come into the office, about 110 of them are subject to no further action. So there is a fair amount of possibility or potential for filtering out cases, without them going into the full machinery of the fitness to practise process. At the request of the Infringements Committee the Inspectorate was tasked at looking at further cases that could be considered for non-referral to the Investigating Committee, subject to relevant criteria. We have further categories of cases which could be subject to threshold criteria. They are listed in appendix 1. When we considered at Law and Ethics we went through the appendix one by one. We are asked to agree the criteria that would be appropriate for the category of cases identified, to agree the action that could be taken in cases that were suitable for non-referral and agree to consult with the members. If you look at the recommendations under 1, you will find a list of exceptions where cases that meet the criteria as set out in this would in fact go through the fitness to practise process. They would not reach the threshold and be dealt with in the informal manner processed. So that is the recommendation before you. We could go through them one by one, if the President thought it was a good idea.

The President: I suggest if there are comments or questions, if we can firstly clear recommendation (i), (ii) and then (iii).

Mr Gerald Alexander: Page 15/17 of the paper, prior allegations, PA1. It talks about five years. Page 16, bullet point 1 talks about three years. I think we are talking about three years, these days. In the last bullet on page 4, or the second penultimate one, we are talking of three years' relevant history. Is there something I missed?

Ms Mandie Lavin, Director of Fitness to Practise & Legal Affairs: Article 15 of the rules sets a five-year threshold. Here we have in effect, looking at the prior allegations alongside the criteria for the single dispensing errors - the point raised earlier by Mr Phillips. I think the whole three year issue is one I suspect we will get a lot of correspondence about in the consultation process. It has certainly been the subject of correspondence in the PJ and the pharmaceutical press generally. That one is there, but the other is written into the rules. I agree it looks like a disparity. At one point, when we originally drafted the criteria that now appears at appendix 4 of that paper, the relevant history was five years, so I think it probably a goalpost that may move.

Mr Gerald Alexander: Finally, if an individual receives an advice letter it goes into their history and remains there for five years, and should a similar or something untoward take place within that five-year period, it is retained and used as history and provided in evidence possibly?

Ms Mandie Lavin, Director of Fitness to Practise & Legal Affairs: It could be, indeed.

Mrs Lorna Jacobs: This was a clarification. On page 12/17, the definitions for grading patient safety incidents which come from the NPSA [National Patient Safety Authority]. In those definitions, they are referring to patients receiving NHS funded care. I appreciate that we are making reference to their criteria for clarity, but I think it should be clear what we are talking about is any patients. I just have an anticipation that lawyers could have a wonderful time on that issue if we do not make it clear it is all patients.

Mrs Lesley Morgan: My point is similar to Lorna. It should include veterinary medicine. If a prize bull gets the wrong medicine it must be inclusive of human and animal, private and NHS care.

The President: Can we agree recommendation (i)? Agreed (ii)? Agreed (iii)? Agreed. Graham, is it about 8(a) or (b)?

Mr Graham Phillips: It is relevant to both but not specific to either. It is a very similar point to the one Sue made yesterday around communication. There are big changes going on here. You know that if I have one criticism of my profession overall, we are unduly cautious and risk averse. Part of growing up as a profession is being prepared to take risks and bend rules where patients clearly benefit.

To create that environment one has to feel if you do the right thing and break the rule for a patient, rather being penalised by your professional body you will be supported by it. The feeling out there is quite the reverse, which is part of the reason why pharmacists are so risk averse. They feel they will not get the support for doing the right thing. We are starting to make a move and we are starting to have a culture change around that. Just simply putting this into a consultation and changing a few rules will not produce the culture change consequent upon it. I believe we need a very clear strong communication strategy, in a number of relevant ways, to make this real, otherwise you will change the rules but you will not change the practice and that will not benefit patients.

The President: I suggest we charge Chairman of Communications and Chairman of the Law and Ethics Committee, to work together to produce a statement which clarifies the intent of this Council. We can refer to previous debates -- I do not want to open it up again, but with respect to previous discussions on this subject, both here and in Law and Ethics Committee, if you can formulate something I will agree a release. Is that agreed, Council? (Agreed) We will go to item 10 (d) before taking 10(c). There is a reason for it. I would like to invite Christine Gray to take us through regulations batch two, report on gazetting.

[On the recommendation of the Law & Ethics Committee, Council **agreed (i)** to extend the categories of cases that were suitable for non-referral to the Investigating Committee under the arrangements for threshold criteria together with the appropriate criteria for non-referral as set out in the paper; (ii) that the specified categories of cases should not be referred to the Investigating Committee and/or be dealt with by the Society other than as indicated in (iii) below, unless one or more of the following statements were true;

- There was potential for or evidence that moderate or severe harm, or death, was caused as a result (NPSA definitions for grading patient safety incidents as set out in the paper).
- There was evidence that there was a deliberate attempt to cause harm to patients or the public.
- There was a demonstration towards a patient or customer, or a prospective patient or customer, of attitudes or behaviour from which that person could reasonably be expected to be protected.
- There was evidence of ill health or of substance abuse by the individual.
- There was evidence that the individual departed from agreed safe protocols or standard operating procedures and in doing so took an unacceptable risk.
- There was evidence that no attempt had been made to learn from the incident.
- The Society had previously given advice that would have prevented the problem if it had been implemented.
- There had been an attempt to cover up.
- There had been an intention to mislead the public or the public had been misled
- There had been a failure to co-operate with an investigation carried out by the Society or other investigatory body.
- There was evidence of other misconduct that would form the basis of a complaint.
- There was a failure to apologise or to provide an explanation to the patient/representative (where appropriate).
- There was evidence that the case met the referral criteria set out in the paper.
- There was relevant history within the previous 3 years.
- There were Controlled Drugs involved.

(iii) that cases which were investigated and not referred to the Investigating Committee should be disposed of by way of a letter sent to the individual by the office as a result of the findings of the investigations, where the individual admits the allegations made and accepts the advice provided. Records should be maintained to show that the individual had admitted to the allegations made and accepted the advice provided and (iv) to consult the membership and other key stakeholders on the above matters.]

10(d) Byelaws to Regulations: Batch 2 – report on gazetting

Mrs Christine Gray, Head of Corporate Governance: The Council agreed at its last meeting to gazette batch two of the draft regulations. The paper before you is a report of that gazetting exercise. The gazetting period does not finish until tonight, so the paper does not ask you actually to confirm the regulations now, but to authorise the President or the Vice-President to do so on your behalf once the gazetting period has ended. The comments that have been received by the office or published in the PJ at the time the paper was prepared are in Appendix B. A couple of further comments have been received since then, which is what Elaine is handing to you.

I will give you a moment to look at that hand-out.

The President: What are the key points?

Mrs Christine Gray: Not much different to those in the paper. They are essentially the same point, but they are further comments so we had to provide them to Council. They are building on the comments that had already been published and included in your appendix. If I can take you to Appendix (b). At page 12 of the paper and look at the comments first of all received from the BPSA on the regulations relating to students. You will see that the BPSA has proposed that in regulations 13.3 the wording is altered from "the Society may maintain an agreement" to: "The Society will maintain an agreement." I am sure the Council will understand and appreciate the BPSA's suggestion, but you may want to consider whether it is appropriate to make that change just now. What I have in mind is when we move to the new regulator and future professional body, we might have a situation where some transitional arrangement might be created whereby the RPSGB's regulations would apply as nearly as they could do to the future professional body until that body had had an opportunity to make its own regulations. In that case, putting in 'will' rather than 'may' might hinder the professional body from perhaps introducing another means of involving students in a membership body, such as a category of student membership or any other similar mechanism that the professional body may want to consider. Bearing in mind the time it takes to change a regulation once in place, you may want to consider whether it is better to leave 'may' rather than 'will' at this stage, but it is obviously for you to consider.

Mr Graham Phillips: We have the chair of BPSA with us. I have a view, but I would be interested to hear Heena's view before I say what I was doing to say.

Ms Heena, Bhakta, Chairman of BPSA: The reason we wanted to change the 'may' to a 'will' was we felt that in the future possibly the Royal Pharmaceutical Society of Great Britain could turn round and say "We are not going to support you". I know that is not going to happen, but that is the main reason why we wanted to change the wording of it. I can understand, with the changes that are going in place, why you may not want to accept that recommendation.

Mr Graham Phillips: My view is that by going with 'will' we are clearly stating an intent, which is important. We are bringing students into the brotherhood of pharmacy, if that is an appropriate term to use. It is all about early professionalisation and accords with everything we are trying to do. In so far as it might create a new restriction, it is a positive indictment, if you like, on the new professional body to engage with students. We have done rather well in recent years, but notably less well in past years and now we have a good working relationship with BPSA. On balance, I accept Christine's point. On balance for me putting 'will' in is the right way to go and sends out all the right messages. If the future professional body needs to make rule changes at that point, it can do so in the light of prevailing circumstances. We can only deal with the circumstances that prevail today and therefore I would support the change.

Dr Brian Curwain: I support Graham. I accept Christine's point but am not certain if the new professional body wishes to register students. It means it should not still have an association with the BPSA. I think the two could go hand in hand. I think we should leave it as 'will'

The President: I saw a few nods.

Mrs Christine Gray: Does Council want to change from 'may' to 'will'? (Agreed) Because these previous draft regulations have had the informal approval of Privy Council advisers, we will need to go back to them and check that change out with them before we will be able to progress it.

Mr John Hanlon: It will be months until you get these changed. The Council had an opportunity when these regulations were before it last time to raise these points. This is the eleventh hour and you are raising it now. It is up to Council. If you want these regulations to be held back for months on one word, based on what we have heard from the BPSA. I can understand what people are saying, but do you really feel this is so important that you have to hold this back for months?

The President: Thank you, John.

Professor Stephen Denyer: John makes a good point. I agree.

Mr Douglas Simpson: This is just a technical enabling measure. I do not think we need to change the word at all. I think 'may' is perfectly adequate. The Council's intention is that we will do that. 'May' allows us to do that. 'Will' is unnecessary. I think we do not need to change it.

Mr Jonathan Buisson: Why does it say "and to make any consequent amendment? "Are we not allowed to?

Mrs Christine Gray: You certainly can, but you will still need Privy Council approval of that amendment. That is what I am saying. If the Council says "We would like this amendment," we will go back to the Privy Council advisers and ask if that is something that they would take on board.

The President: I think, Council, we do not want to delay this. This is something where we can perhaps note some comments which future Councils will take into account. I think that is a reasonable way to go forward.

Mr Graham Phillips: A practical way forward I accept that in the circumstances. Having done that, could we not put forward a further amendment for their considerations in due course so the thing is in the process?

Mrs Christine Gray: I do not understand question.

Mr Graham Phillips: I suggest we seek the agreed amendments for now and we then put in for a further amendment to change that word and if it takes a few months, or however long it takes, it takes that long, but it means we are moving the game long.

Mrs Christine Gray: The Privy Council advisers would not take kindly to us putting in regulations for formal approval then immediately saying we say we would like to amend them.

The President: We are making heavy weather of this. I think we have had enough debate on this. The mood of Council is not to support the proposal by Graham, so we will move on. Are there any other points?

Mr Gerald Alexander: Just to support what Doug said and to reinforce it. The intent of the Council is clear. If that is recorded in the minutes, any future Council would understand that. So leaving the suggested regulations as the Privy Council have already seen, not to delay the regulations going through, I think we should support Chairman of Governance [Committee]. But this Council should be clear and any future Council and professional body should be clear of the intent of this Council and that should be recorded in the minutes.

The President: It can only be advisory. We cannot bind a future Council.

Professor Bob Michell: My comment relates to the paper that has been tabled. It takes me back to something I did say in the earlier discussions. It certainly does not mean we should change anything with the Privy Council, because it is far too late. But this paper shows that we need to clarify something that I pointed out in previous discussion, and it is this. The problem with the term emeritus is that almost everybody who has not actually been employed in academia totally misunderstands what it means. It sounds as if it is an award for merit; it is not. It is an award purely for long service. Hence when people argue about it is an honour and we should have post nominals, it is not actually an honour; it is a privilege. It is a recognition of long service. In academia when emeritus status is conferred all it says is that you have served long and did your job properly. No CV is submitted, no publications. There is no merit. It is nothing to do with honour.

The President: Thank you for clarifying that. I think it is important for clarifying people's thoughts, and we are in public business and I am sure people will note what Bob said. Action required. Does the Council agree (i)? Agreed. (ii)? Agreed. Thank you for all the hard work, Christine.
8(c)

Can we go to eight sorry 10(c)?

[Council noted (i) the report on the gazetting of the Regulations to date, and (ii) that the approval of the Privy Council advisers would have to be sought for the clarifying amendment proposed to 13.1, before the regulations could be submitted for approval, and agreed (iii) that, as the gazetting period closed at 23.59 on 12 December 2007, to authorise the President or Vice-President to approve the submission of the regulations to the Privy Council for approval at the end of the gazetting period, pending agreement of the Privy Council advisers to the proposed amendment.]

10(c) BPSA-RPSGB agreement

This is the BPSA Society agreement. We are asked to consider and approve a draft agreement between the Society and the BPSA. C/121 is in your agenda papers. The paper before you seeks the Council's approval of text for an agreement between the BPSA and the Society, this draft agreement picks up on some of those details that we are now proposing to carry forward into corresponding regulations. Council members will be aware that there is a close, thriving and multifaceted link between the Society and the BPSA. A link that the Society greatly values as a conduit to student opinion and is keen to maintain. It is entirely appropriate for us to foster links and communication with prospective members of the profession. The draft agreement before you is part of an on-going drive to maintain and enhance that relationship and I commend it to you. Before I hand over to Elaine to give more background, I would like to offer the BPSA President the opportunity to say a few words.

Ms Heena Bhakta: I want to say thank you to the Society for this agreement. I think it is something that will continue to build the relationship between the BPSA and the Royal Pharmaceutical Society. I also thank you for the support that the RPSGB give to the BPSA. Without you we could not do what we do, which is serve members, who are students and future members of the profession.

The President: Elaine.

Mrs Elaine Mulingani, Internal Governance Co-ordinator: Once again this paper originates from the policy decisions that the Council took back in August 2006 to inform the drafting of batch two of the regulations. The draft regulations that you have just discussed read "in pursuance of its objects the Society may maintain an agreement to co-operate with, consult and support an association of students called the BPSA. We have accordingly drafted text for such an agreement, which you will find at Appendix B of the paper. As the President says, it picks up on some of those areas that were in the byelaws and have not been carried over into the regulations covering students. As ever, we have done things this way simply because our general goal with the regulations has been to limit the amount of detail that they contain and, so far as appropriate, to capture the rest in protocols and guidelines, while avoiding improper sub-delegation. Are there any questions or comments on the text?

Professor Stephen Denyer: I have an observation, which I have only just realised in reading through on page 2/4. It is under the excerpt for our draft regulations is currently being gazetted. It is section 13.1. I do not think this requires any change to what we are gazetting but it may be worth making a record of our realisation. We have three schools of pharmacy now that have two plus two programmes, where the first two years are taught in overseas countries and the final two years in the UK. I think we should recognise that we would want to extend the sense of that section 1 to include students on the first two years of a UK accredited degree but undertaken not in the UK .

The President: That is a sensible suggestion. I commend it to you.

Mrs Elaine Mulingani: As I understand it, the text does cover that.

Professor Stephen Denyer: You might be right. I have re-read it and was uncertain, so I thought it might be useful to declare an affirmation on that.

Mrs Elaine Mulingani: Absolutely. We thought of that and so far as we can see the wording does cover that.

Mr Alan Kershaw: I am not sure it does because of the words "school of pharmacy in Great Britain." If the words "in Great Britain" were omitted from paragraph 1 here, the sense would not be lost;

nothing would be changed except it would be clear that it included those who were not studying in Great Britain, but were part of that school of pharmacist.

Mrs Christine Gray: Sue, I do not know if you can help us. I have a vague recollection back in August 2006, when we were developing the policy proposals for this, that it was two plus two courses are degrees of schools of pharmacy in Great Britain, no matter how much time is spent outside.

The President: Alan is saying, if you removed "in GB" it would not alter the situation.

Mr Alan Kershaw: I am aware that at the school I was involved in inspecting a couple of weeks ago, it is part of their credentials that the students are encouraged to be members of the student Society of the University in the UK, even while they are studying in Malaysia. I think the problem is the words "at a school of pharmacy in Great Britain." If we take out the words "in Great Britain" and leave it tied to "university or school offering a registerable degree," that is all that matters.

Mrs Elaine Mulingani: Could I clarify? You are seeking a change to the regulations?

Mr Alan Kershaw: As we are being gazetted I think we have the opportunity to do it.

Mrs Sue Kilby: I know we oversee the course in Belfast, but I did not think Northern Ireland was actually in Great Britain at the present time.

Professor Stephen Denyer: Having not volunteered to suggest a change to what has been gazetted, I am happy to do so, but mine is a more subtle change: On the first sentence to change 'at' to 'of.' I did not mean to start a hare running with Belfast.

The President: I think the words include Belfast I would rather get it right than worry about it afterwards.

Mr Bernard Kelly, Director of Finance & Resources: I was going to suggest the appropriate wording be "a school of pharmacy accredited by the Royal Pharmaceutical Society of Great Britain."

Professor Stephen Denyer: Sounds good;

Dr Sue Ambler, Acting Director of Education & Registration: I think we know what we are trying to achieve. If Council is happy, we can check it with Damian that we get the right wording for students doing an MPharm programme.

The President: I think that is a better way. Can we agree the action required to approve the text of the agreement, subject to our discussion being taken into account when finalising the paper?
(Agreed)

[Council approved the agreement as set out in the paper.]

11. Patient and public involvement, first annual report.

I would like to invite Brian Curwain, who has been involved in the PPI initiative. Eileen you can add any additional comment or answer questions.

Dr Brian Curwain: As you say, there have been a number Council members involved in sponsoring the patient and public involvement work. It is myself, Lorna and Ray. This is for noting. We will try to take questions or refer them back to Vanda. There are a few points to make. There is now a dedicated post in the Society established for two-third of the year which is a part-time post by Vanda Thomas. She has done a lot to start to bring a PPI agenda forward within various parts of the Society and also outside. So we have now a public liaison group, and also a staff operational group. The first is chaired by Lorna and the second is chaired by me. The thing I would like to draw your attention to are that the main task initially has been raising an awareness of PPI within the Society, and I think we are making some progress with that and of its benefits and the reasons why we have to do it and should do it. CHRE is one of the reasons why we have to do it, of course, as you can see from this. The Public Liaison Group is quite active and is keen to take on board some priorities from the Society.

They meet both virtually and under Lorna's chairmanship, and she may want to say things about that. If there are other questions, then we are prepared to take them. I would like to commend Vanda's work. She tells me there are now a number of enthusiasts around the building for PPI in a number of directorates. She is exploiting that and developing the work and we look forward to producing a fuller and more detailed report in a years' time.

Mrs Sylvia Hikins: The only comment I want to make was on page 2 of the report -- and I thought it was a very well-written and clear report -- at 2.2 outcomes, disappointment at the lack of administrative support. I think it raises questions around a number of work streams within the organisation that we focus so much time and effort and financial investment in the changes that are being, if you like, thrust upon us. There is a lot of other quite core work that probably is suffering and this is one of them. I would urge us at the earliest possible time to have a look at the administrative support requirements for PPI and see if we can do something about it.

The President: Can we note the point and come back to you at the next Council meeting? We will need to consult.

Mr Ray Jobling: President, can I draw attention on 5/8 to the pilot projects and to the fact that we are on long-term conditions under practice pharmacy framework. Both of those are absolutely integral to the way forward in the Society and the leadership the profession is going to give, not only internally but throughout the health professions. It is significant that work has already gone forward in these areas.

The President: Any other comments or questions? I want to raise something after reading the paper. I think we are going through big changes in the profession. We are ambitious and we want pharmacy to be a clinical profession. In the NHS, patient and public involvement is quite an important initiative. My question is what are we doing to inform, educate and support pharmacists to develop a better understanding of what PPI is and why it is important to their practice. Is there anything being done by the group to address those issues?

Ms Eileen Neilson, Head of Policy: It is a very important question, and it something that came up at an early stage in the development of the strategy. The feeling at that stage was that we needed to get our own house in order before telling the profession that they needed to become aware and start thinking of how patient and public involvement affected their practice. One thing I would say is that Alison Blenkinsop has recently prepared a short paper for us on how MUR might have developed differently had patients been involved more in the planning stages. We are going to draw on that paper in our submission to the Clarke Inquiry and potentially add it as an appendix. I will circulate it to you, as I think it is a very interesting paper and illustrates exactly what the President is talking about.

The President: Thank you, Eileen. If we need to have a discussion about it, we can pick it up at in the early New Year. Can we approve that report for publication? (Agreed) Thanks for the good work.

12. Recognition of pharmacist prescribers and the use of post nominal initials

We have discussed the item in the past and I think Peter Wilson is going to introduce paper C124.

Dr Peter Wilson, Head of Post-registration: As the President reminded us, this item was discussed at the October meeting of Council, and Council expressed one concern which was that we should understand the views of patients and the public on the use of post nominals in pharmacy, and secondly that you should be presented with a range of options from which to select a post nominal. I took the question about post nominals and pharmacist prescribers to the PPI group at the meeting in the Autumn of this year, the meeting that took place between last Council and is today. I put the question to them and their answers were extremely direct, almost combative. They want to know that a pharmacist, whether practising as a pharmacist or a prescriber, is competent and trained to do the job they do and that they are safe. They do not see post nominals as conveying that information. They see those as confusing and irrelevant. I said "How would you regard MPharmS, instead of something abstruse, like pharmacist prescribing?", and the answer was exactly the same. So my conclusion, because the PPI is but a sample, is that the use of post nominals is something which is recognised by those patients and members of the public who understand them.

They are important to employers, to recognise the qualifications of the people they employ, and they are important to some professionals, because it is a recognition of their achievement. You will recall in our original discussions of the use of post nominals by pharmacist prescribers that those were the reasons why they were asking for permission to have an officially sanctioned post nominal for their prescribing status. For the second request from Council, with the help of an ice pack and a quiet room, I carried out an analysis of how you might take forward the formulation of an appropriate post nominal for pharmacist prescribers. It has been a salutary experience. I thought I had done quite well, then two members of Council rang me before the meeting to suggest something far more eloquent. I am grateful to Steve Acres and Brian Curwain, both of whom suggested that the simplest way to approach this is to forget all these letters, but put a simple bracket after the end of MPharmS and to indicate inside the bracket that the pharmacist has prescribing status. Steven suggested PRESC (prescriber). Brian suggested we use the letter P. I present to you the elegant concept from two of your number, and the more complex approach of 64 choices which I have I put before you for Council to discuss.

The President: As long as it is not PRES I do not mind! I think everybody will have at least one preference, and to get agreement may be a bit difficult. So I would say on this particular issue, looking at the paper early this morning, I thought to myself perhaps I should have asked the Council to look at this issue on a strategy day, so everybody can have a good input into it and come to a conclusion, because around here trying to take 30 different opinions will be difficult, but I am in your hand. Is there a rush for a decision, or could we take it up on a strategy day and have a really good discussion about it?

Ms Marcia Saunders: I suggest we take it up at on strategy day because otherwise, harking back to our earlier decision, we may loose the will to live. (Laughter)

Mr Graham Phillips: I would rather delegate this. There are far more important things to do on strategy days than argue on 60 versions of post nominals. I am happy to take a recommendation from the office.

Professor Bob Michell: I would like to fly a kite. I think Steve's suggestion had a clarity which commends it. I think from the point of view consumer, the abbreviation PRESB is closer to prescribing than P, which could mean physician, psychiatrist or all sorts of things. I think if we do it on a strategy day how many angels will dance on a pin but for how long.

The President: The body language indicates that there is some agreement with your proposal. So Council, is there consensus? (Agreed) It is PRESC.

[Council noted (i) progress in the delivery of the PPI Strategy as set out in the paper, and approved (ii) the annual report for publication.]

13. CPD for new roles in NHS pharmacy services - the role of the Society.

We have paper C125 in the agenda papers. Peter will talk us through that.

Dr Peter Wilson, Head of Post-registration: The paper is here at the request of Officers group and stimulated by the content of the June report of the All Party Pharmacy Group. In that report, there is one recommendation, which is that pharmacists should be paid for the time that they spend undertaking CPD. It was on the basis of that recommendation that the Officers group asked if I would prepare a paper for today. The content of the paper reflects the discussion in Officers group, which is contained in the minutes of the Officers group meeting. In preparing the paper I have looked at the wider context of the APPG report to formulate proposals which I am presenting to Council today. One of the requests of the Officers group is that this particular issue should be discussed between the Officers group meeting and today with Jeanette Howe at the Department of Health. I understand that has happened. Jeremy Holmes went with Sue Ambler. I was on annual leave at the time and missed the meeting, but my understanding is that the principles contained in the paper are consistent with existing Department of Health practice and experience. Therefore, they do not necessarily conflict with directions of travel within the Department.

So briefly, in addition to the recommendation for payment for time spent in CPD, the All Party Pharmacy Group spent more time talking about the new clinical roles which pharmacists are going to be drawn into in the future and the ways in which those roles might be supported, both in terms of encouraging pharmacists to acquire the necessary competence to deliver new services, but also in the way in which pharmacists and particularly general practitioners might interact in the quality framework and the payment for it. So the basic thesis of this paper is that payment for pharmacists who engage in professional development in the future should, as in the past, be linked to the services that pharmacists deliver as a result of successful and accredited professional development, rather than the discredited mechanism -- I say discredited from experience with general practitioners -- for paying people to turn up at education events and then watch them disappear out the door or fall asleep, which has been the experience in the past. There are a couple of risks associated with this, and it is for you decide how serious they are. The first is that this is a pay and rations issue potentially. That is not an area of practice in which the Society has been explicitly involved in the past. There could be seen to be boundaries between the role of the Society and the role of the PSNC in discussing payment for community pharmacists. That does not of course exclude the possibility that the Society and the PSNC should, as in the past, co-operate in promoting this approach to the Department of Health. The second is that payments to community pharmacy for services tend to go to the contractor, but it is the individual pharmacist who is delivering the service and could be looking for the Society, professional leadership body, as it will be, to support them as individuals in their professional development and in their reward for that. The essence of the paper is that the Society should promote in principle an equality of services and an equality of reward framework for community pharmacy services, arising from the APPG report and that this should be a co-operative venture across the other stakeholder bodies in the profession.

Mr Martin Astbury, The Vice-President: Thank you for the excellent paper we have. I spoke to Peter earlier and the suggestion that I am going to make will not go against anything we have discussed with Jeanette Howe, or will not affect any of that. Certainly when I first broached the subject in I think the Council meeting in October and then through Officers, I did not expect recommendation (i) to appear. I feel that we can stay neutral. I am not going to recommend that we vote necessarily against option (i), but I suggest we do not take (i) at all. We can take option (ii) and (iii). Those are positive options and ways of looking at funding, but we do not have to close the door and make any decision in any shape or form on option (i).

Mr Graham Phillips: I think there are some really significant philosophical issues here. The first thing I want say is that I absolutely reject the concept that as a professional you only do what you are paid for; whether in terms of services to patients or in terms of keeping up-to-date professionally. I would make it absolutely clear that I think any professional has the responsibility to maintain themselves up to date. That said, there is always a 'but' isn't there? Look around at what we are asking pharmacists to do. I look at the type of training pharmacists were given in their undergraduate courses. I look at what the future requirements for a clinical profession are and the resources that pharmacists were given in their formative years as undergraduates and I look at what is on offer currently. Then I look at the kind of changes the medical profession has brought about. For example, the way general practice has moved forward astronomically in the last few years and so much of that is around support and resource. We do not have a deanery structure. We do not have the support mechanisms that they have do. So if you want to do postgraduate work in pharmacy, it is almost done in your own time and at your own risk. Of course, there is that responsibility. The majority of postgraduate, particularly in community, is CPPE, who do some absolutely fantastic work, but it is done in an incredible shoestring Let me paint you the picture of my day. You work nine to seven flat out. You are exhausted by that stage. You then go and do what urgent deliveries you have to do, and so on and so forth. By the time you get to the CCPE meeting that started at 7.30 with sandwiches, and the actual learning starts at eight, the food is finished. You then spend two hours trying to do your professional development. That is the reality of the working life of community pharmacists, which is fine if you are given resources in other ways, but you simply are not. It is not built into the system. I know GPs who get one year sabbaticals, they get protected time. They get all sorts of other support. It seems to me at some point, as a professional leadership body, you have to make a stand and say the resources available to pharmacy at all levels are simply inadequate for the tasks that are being required of us. I believe this is one of those occasions -- and yes, I accept there is self-interest in all of this -- but I think there is an overwhelming patient interest in bringing the profession to where it needs to be.

Therefore I believe we should be making a stance, not about the quantum, because that is not our role, but to recognise the resources individual practitioners need to deliver what is required. I think we should take a lead and be prepared to have something around the requirement for some investment here.

Mr Gerald Alexander: I largely support the Society's involvement in the promotion of services linked to CPD. I just have one or two questions. Obviously I would support Graham in relation to pharmacists having protected time for learning, but sadly that does not exist at the moment. I wonder, where we are talking about co-operative venture with other stakeholders in the profession, I wonder what sort of contact we have had with PSNC over this before this paper was written. Could you tell me?

Dr Peter Wilson: I have had no contact with PSNC over this. The suggestion I am making is that if Council agree with the suggestion that I have put into the paper that should then begin, but I would not have done that without first coming here.

Mr Gerald Alexander: I thought there might be some informal contact at middle management level that would have taken place prior to the paper being written. Just to let you know that within funding for MURs within the new contract for pharmacy, there is financial support actually built into that payment structure. The payment provision actually makes available some element for learning and time, so it is built into the negotiated structure of the payment that is received by contractors. The other point I want to make on point 2 on the risk implications is that I am not entirely sure what you mean by "if contractors were rewarded by a new quality reward framework supported by the Society individual members could be could feel let down by their professional body." I do not understand that.

Dr Peter Wilson: If the Society promotes a quality and reward framework for encouraging the development of community pharmacy services, community pharmacists who undertake the professional development and possibly pass an assessment to become qualified to deliver a new service and then find that the cash flow, the reward, goes to their employer and not to them as an individual, and is not passed to them by their employer, which is at the employer's discretion, then they could feel let down. That is the point I am making. It is a risk. You may discount it; that is fine.

Mr Gerald Alexander: As long as we fully understand it. What I am trying to say is that I support the recommendation in (iii). I think our situation in (i), our Society policy, should not alter -- not for the time being anyway. We should be associated with this, but in moving forward I think we should at least, if we are considering our position as a professional body, I think we should have closer contacts, at least telephone contacts. I think this is the normal relationship between bodies. If we are going to have joined-up thinking in pharmacy in the future, I think we need a better relationship. It is not critical in any way, but I think relationships should be ongoing. The staff of the various organisations out there talking to each other before such papers are presented to Council such as this. I would support regular contact at middle management level in order to build on those relationships to find out where other the organisations sit in relation to how we intend to take things forward. That is all I would say. It is a caveat and no more than that.

The President: You make a good point and I am sure it will be noted, because this is an issue which has two clear remits. We are responsible for CPD. PSNC is responsible for negotiations and we will in the future bear that in mind.

Mr David Thomson: It is a commendable principle and certainly worth of support, but it is very much weighted towards practice in England. I want know what dialogue has been established between Scottish Government, community pharmacy in Scotland and NHS education for Scotland.

The President: My guess is that this paper was written to meet the requirements of the Vice-President, who requested this item at a Council meeting. I am picking up that there is need to have dialogue with other bodies in all three countries in order to take the matter forward. We will do that. Is there any additional comment you want to make, David?

Mr David Thomson: I am reassured. It is partly as a GB-wide organisation this should have been a principle embedded in the paper at the outset.

The President: We will make sure that we look at a GB-wide view. Where there are differences, we take those differences into account.

Mr Frank Owens, Vice-Chairman, Scottish Pharmacy Board: As past chairman of a pharmacy negotiating body, as you might expect anything to do with pharmacy funding sets my little heart a flutter. However, I recognise we are not a negotiating body here, so I am going to restrict my comments to two main areas. I have read this paper very carefully. Whilst the payment per se for completion of CPD, I agree is inappropriate, nevertheless, the provision of incentives to encourage professional development, particularly where it is linked in some way to service delivery, I believe to be a very sound proposal. In Scotland we have used this tool of incentive payments across a whole range of different areas. So we have used it for IT and for premises upgrades. We have used it for support staff training. We have used it for security in pharmacies and now we are using it in Scotland for CPD. Rose Marie Parr, as Director of Pharmacy at NHS Scotland, has done a fantastic job in Scotland preparing and managing all sorts of CPD packages and all linked into the new pharmacy contract. Over the forthcoming period she will be working on four main areas: CPD, rheumatoid arthritis, on the acute medication service that is due to come out next year and on the chronic medication service. So far all these packages have been very successful. It does not cost an awful lot of money, but it is a main driver for pushing the practice of pharmacy forward for giving pharmacists the tools and the necessary support to deliver that new contract. So I would commend the concept of incentives because they do work. The other area I want to talk about, is with regard to developing incentives with regard to general medical services. I think that is a great idea, if we can pull that off. The key message there is not about competition but about collaboration. It is about all the disciplines working together to the benefit of the patient. Again, I would say if you can get the QAF framework, or if the medics can get the QAF framework redesigned in a such way that they are rewarded for engaging with pharmacists, the profession could take some enormous steps forward. There are some big pluses in it for medicine too and for patients, of course.

The President: It is useful to get that insight from a negotiator.

Mrs Sue Kilby: It was really to highlight the complexity of the whole issue, because it is not solved by one simple step. I do totally endorse what Gerald is saying, and I am somewhat surprised that there has not been some informal contact with the other organisations; obviously the PSNC and also the CCA as well around this particular issue. But I have also concerns about the fact that there are a lot of people who work within community pharmacy who would not necessarily be directly represented by those particular organisations, and we are actually trying to look at those people like, for example, the locums. Also people working within primary care, and maybe also within the hospital sector as well. If we are talking about improving NHS services within the community sector, we need to be thinking of how we ensure those people are also perhaps looked after around the CPD issue. So it is almost as though we are opening a huge hornets' nest in thinking about this in general. I am not against it, and I totally endorse what Graham says. We do need to look at this issue, but I do not think it is going to be one easy step. It is going to involve a number of aspects and we need to bring it all altogether, so it is not an easy challenge.

Mr Ray Jobling: I hear what Graham Phillips was saying and I have been listening carefully to Frank's comments, which I found extremely interesting and very helpful. Things said by Scots usually do have that effect upon me. They speak with a clarity and with a force. But I am hearing a lot of this for the first time as a lay member, and I have been a fellow traveller of pharmacy for more than a decade. I think that is for a reason, which is that lay members are not informed as to the financial reimbursement side of the profession and what goes on. It has not been part of the business of the Society that I have listened to and taken part in for these several years. I am not trained for it. I am not briefed for it. I am not saying it is unimportant; it clearly is extremely important. Graham has made the point and it has been reinforced by Frank. I have no trouble with (ii) or (iii), but I think I would have to abstain on (i) for the reason I have just given you. I think it is as well for the Council to take that into account. The point has just been made. It is taking us into completely new territory for some of us, and takes us across into an area which I have seen very much as part of the PSNC's work, and those are dark arts.

The President: I think what the Vice-President suggested was that we leave (i) and not vote on it. I see general agreement on that. Can we clear that up, that we remove (i) and we concentrate on (ii) and (iii), in terms of comments and discussion.

Dr Brian Curwain: I do not need to say very much, because I was supporting Martin. But I do think it is inconceivable that a new professional body would not be lobbying for support of CPD and the development of some sort of deanery structure. Let us strike off (i), agree the other two and have some coffee.

Professor Bob Michell: It is inevitable that the new regulator, quite rightly, will insist that CPD becomes mandatory. It will not be popular, but it will be absolutely right. There will be a consolation prize. The consolation prize is that at that point the cost of CPD becomes tax deductible. That may be important, particularly for locums who do not necessarily have an employer who is going to pay them to do CPD. My other observation is purely for your interest, and you can talk about it over coffee, but it is to support Graham. If I look at my own profession, the veterinary profession, young veterinary graduates, who are under at least as great pressure as Graham indicates for young pharmacists, evidenced by their enormous suicide rate, who have just spent the best 20 years of their lives passing one exam after another, what do they do next? A very high percentage enrol for a postgraduate certificate -- not a diploma. A diploma leads them on the path to specialisation -- a certificate. A certificate does not increase their earning power. It does not increase the income of the practice. All it does is to increase their professional satisfaction and confidence in understanding what they do to a greater depth and doing a better job. We hear too much about market economics in the Health Service. As Graham said, let us think more about professional value and commitment.

Mrs Dorothy Drury: Because under recommendations we are scrapping (i), would it be appropriate to change the word 'reward' to 'the need for adequate resources'?

The President: Reward is not just financial; it is more than that. I do not think we would gain much by changing it. I think reward is financial and non-financial.

Mrs Lorna Jacobs: I was wanting to put forward a thought, following on from discussion last night, where we were talking of the need for something like a strategy day to look at practice-based commissioning and what are the drivers and what are the obstacles and how, as a Society and as a Council, we can devise strategies to help people overcome them. It seemed to me we could be talking a similar sort of strategy day, looking at this idea of the quality and outcomes framework. Would it be possible to have something like that, bringing in other organisations into such a strategy day? Maybe I am naive to suggest it.

The President: I think the idea is a reasonable one, because it promotes collaborative working, which Gerald commented upon. We are in public business. It is a good idea worthy of exploring, but I do not think it is going to happen tomorrow. It might take a bit of co-ordinating, but we will consider that.

Mr Graham Phillips: I would like to support what Lorna said. We are at a tipping point in pharmacy education. If we want to move the profession forward with the vision that I think is agreed around this table, we need to have a real debate around pharmacy education. We are kind of at that point. I have suggested the whole of pharmacy education -- and I talk of a cradle to grave relationship here -- be brought to a strategy day. I keep on batting on about it, and I think people get 10 percent of my message, but it will have a very profound influence. I have made the suggestion at Officers that we do this as a strategy day. We could wrap all of this around it and take up what I think are very helpful suggestions from Lorna and Ray.

The President: We will look at that.

Mrs Sylvia Hikins: I do not want to prolong this, but I do not think Lorna was suggesting that. I think she was suggesting linking it to practice-based commissioning, which is a slightly different take.

The President: I think there are two separate ideas. That is the way I was looking at it. There are two separate ideas, and we will certainly -- I think we need to have a chat separately. I think we will need to have a chat with each one of you separately, so we have absolutely clarity about what your intent is. From where I am sitting there were two separate ideas. Can we now take (ii). Is that agreed? (Agreed (iii)? Agreed. Thank you. We will break for coffee for 15 minutes.

[Council agreed that the post nominal initials "MRPharmS(Presc)" be used by pharmacist prescribers and FRPharm(Presc) by pharmacist prescribers who were Fellows of the Society.]

(After a short break)

15. The Portugal Agreement under the Health Professionals Crossing Borders Initiative

We are going to take item 15, the Portugal Agreement under the Health Professionals Crossing Borders Initiative. Paper C/127 has been prepared by Martha. To talk us through the paper, I will invite Martha.

Mrs Martha Pawluczyk, Overseas Registration Manager: Good morning. The Portugal agreement is an extension of the Edinburgh Agreement of October 2005. That was signed with an intention of having a life up to and including coming into force of Directive 2005/36/EC. That happened on 20th October of this year and the Portugal Agreement is designed to build on the principles of the Edinburgh Agreement in agreement 1 and 2. So it builds on and encourages other regulators across Europe to have accessible web-based searchable registers of members/registrants and to try and make their disciplinary processes transparent to both regulators and members of the public. It then builds on the Memorandum of Understanding that the Council agreed that the Society become a signatory to in October and encourages, and Council agreed that the Society should also encourage the competent authorities that it works with to become signatories. The aim here is that when professionals move, the information of any disciplinary sanctions that they may have acquired during their working life also moves with them. Most interestingly, in agreement 3, the Portugal Agreement tries to ask competent authorities to work together to determine what sort of performance assessment and competence assessment tools they use within their own Member States to ensure the current competence of their practitioners, and sharing this sort of information could actually be very, very useful in the future, when it comes to revalidation. I suppose, the fear there is that people might want to move to avoid revalidation mechanisms perhaps in their own Member States. It would be interesting to know where in a revalidation cycle a particular professional may be when he does move, so that appropriate measures can be taken if he is still working in another Member State at the revalidation point for his own Member State. That is the agreement. It is in draft format. That is the latest draft I had and I have not had a subsequent one. Under agreement 3 there will be a lot of information gathering and networking with competent authorities. We already envisage that as a requirement on us because of the new Directive and a spirit of cooperation with other regulators and we will be actively be doing that. I ask you for your endorsement of the agreement. (Agreed).

Mr Ray Jobling: I do not want to put a but in, while everyone is smiling. I am fully supportive of the helpful paper on 2/14 under 2.3 through to 3 and risk implications. It talks about the way in which this is part of the broader agenda; that is to say, this is probably the good bit, and there are other bits which are not perhaps quite so good in other ways. Can I beg that as things to go forward -- because I have been speaking to Martha outside about some of the draft proposals coming forward as part of the Commission's objectives in relation to health services Europe-wide -- that we do get a subsequent briefing and updated later in the year as to where this bit fits with what we now know will come. I think Martha was saying that the Directive on patient mobility will come out in its draft form fairly shortly.

Mrs Martha Pawluczyk: Either 14 or 19 December. It has been extremely contentious even in its draft bits. AURE have been lobbying in Europe for the inclusion of a legal duty on information exchange, which has not been taken on board, although it did get MEP support, and the very contentious issue of the recognition of foreign prescriptions, EA prescriptions, is included in that document as it stands at the moment.

Mr Ray Jobling: That is to say, President, placing a duty on a UK pharmacist to deal with a prescription which is written elsewhere in Europe.

Mrs Martha Pawluczyk: I do not know how it will be worded.

Mr Ray Jobling: It can be worded better than that, I am sure. (Laughter)

[Council endorsed the Healthcare Professionals Crossing Borders, Portugal Agreement, 2007, and noted that further updates would be circulated to the Council.]

The President: Can we go now to item 16.

16. Procedures for processing applications for "visiting EEA pharmacist" status from persons with non-compliant qualifications/work experience.

Mrs Martha Pawluczyk: I feel as if I have spent the entire year coming before Council and talking about this Directive in one shape or form. This is the last piece of the jigsaw, so to speak. The Directive has now been implemented into UK legislation and we do have two new statutory instruments. SI 2007 3101 is the one that has created Part 3 of the Society's Register for visiting EEA pharmacists and pharmacy technicians. In the processing sphere, we have four categories of applicant. We have applicants that comply with the Directive requirements who want to join Part 1. We have the ones who comply with the Directive requirements who want to join Part 3 and for those two categories of applicant, when they have got work experience or a qualification that complies with the Directive the Society, having satisfied itself as to the applicant's good health and character, cannot competency assess or look at that applicant's qualifications or work experience, but put those people on to the Register.

Council approved a paper-based assessment process in August 2003 which is included here which is for those applicants who have non-compliant qualifications or non-compliant work experience. This paper proposes that the same paper-based assessment is utilised for applicants wishing to join Part 3 of the Register. So that is the first recommendation.

Mr Alan Kershaw: I will not rehearse the well-known arguments about why the Directive poses serious risks, but for those who comply. For non-compliant, I just wanted to say, from the joint of point of the Adjudicating Committee's work the, paper-based process is working quite well. It was initially extremely laborious. We have recently instituted quite a useful change, which is making it a great deal easier to do. I think it works fairly adequately with individual members sending in comments and proposals. As far as I understand, we do not differ wildly in what we propose in each case, so it is fairly easy for the office to construct a consensus from that. I would commend this as a way of dealing with these cases too.

The President: Is that agreed. (Agreed).

Mrs Martha Pawluczyk: For those applicants joining Part 1, in June of this year Council agreed that they would be required to do an adaptation period with assessments, which would be linked to the pre-registration competencies in the workplace, signed off by a supervising pharmacist who we recommend for the time being to be the tutor. In the case of Part 3 applicants, an adaptation period is not strictly feasible. There are incredibly strict time limits. I have now looked at the Department for Innovation, Universities and Skills advice on how we are to proceed within those time-scales. The long and short of it is that once we have decided that there is a non-compliant applicant, we are going to check their qualifications. We have a month in which to obtain the information from the applicant. If that information is not forthcoming, it does not mean time has stopped; time continues to run. So the assessment will then have to be done on the information that we have. I think then there will be gaps identified, almost invariably, and the gap can only then legitimately be rectified by asking the applicant to take an aptitude test. We have gone to the Board of Examiners with the proposition and they can see the dilemma of the need to design an aptitude test within a month of the decision, and are supportive of the aptitude test being based on the Society's registration examination.

The President: Can we agree (ii)? (Agreed)

Mrs Martha Pawluczyk: The Board of Examiners, as gatekeepers of the hallowed bank of questions, are very concerned about the integrity of the registration exam. We explored at their October meeting the format that the aptitude test could take. They favoured an oral structured examination, based on the areas identified as missing, preceded by some sort of practice-based scenario questions that the applicant would have time to prepare immediately prior to the interview. That paper would be collected and they would then be interviewed, based on the bank of subjects found missing and selected questions that they had prepared in advance and also asked questions on their responses to the scenario questions which would be dispensing focussed but practice focussed ethical problems possibly, and their reasons for the responses they had given. So that is the proposal initially for the format of the aptitude test. Obviously this would be reviewed in the light of experience.

So that is the third recommendation.

Mr Martin Astbury: What fee do we charge? Is this an application to the register fee that someone would have to pay, because they are an EEA pharmacist, or is it a different fee? This is a very expensive process potentially here -- very expensive. Are we limited to what fee we can charge?

Mrs Martha Pawluczyk: Applicants joining Part 3 of the Register cannot be -- the mutual automatic ones cannot be charged any processing fee or registration fee. Registration with the Society is a pro forma process, which is literally automatic and at no cost to the individual. The rationale for that, according to the EU Commission, is that the individual continues to pay a fee to enable them to practise in their home State of establishment. These are people who are only coming to provide services on a temporary and occasional basis, so there would be no fee for those. It is proposed for the ones who undergo the comparative assessment. In the Society's fee consultation document, in the Fees Rules section, there is an EEA comparative assessment fee payable that is set for 2008 at £631. I am proposing that the same fee is charged of Part 3 registrants undergoing the comparative assessment. In the byelaws the Adjudicating Committee has a fee for interviews which is also set at £631. The proposal is that the comparative assessment fee is charged. If it looks that there is sufficient information that the assessors are happy to let the individual on to the Register without an aptitude test, that would be the only fee payable. If an interview with the Board of Examiners is deemed to be required, that information with the assessment and the gaps is passed to the Board of Examiners and then the interview fee of £631 is applied at that stage. I am not pretending that is on a full cost recovery. I actually do not know -- although in our Frequently Asked Questions we warn people there might possibly be full cost recovery. The advice of Department of Health is that it is legitimate to charge a reasonable and proportionate fee for the aptitude test. That is the proposal before you today with reviews in the light of experience to inform fee consultations in 2008.

Professor Bob Michell: I am very pleased to see that there is this oral structured exam. I think it is particularly important, bearing in mind what we have just seen in the Portugal Agreement, that patient safety should be the overriding issue. It is quite clear that in any healthcare situation -- it doesn't matter whether it is animals or people -- it is often not a failure of knowledge that creates problems, but a failure to correctly and actually communicate knowledge, and that cannot be tested by a paper-based exam. Nor is it just a question of what used to be called the Queen's English, particularly on ticklish matters like healthcare matters. It is the importance of understanding vernacular English. It may appear unfair, and indeed it may be, but it is absolutely decisively central to patient protection that someone who is potentially going to be a high street pharmacist in this country, should have the ability both to communicate clearly and to understand accurately, including a reasonable range of vernacular English -- not Glasgow, not Cornwall but a reasonable range of vernacular English. (Laughter)

The President: Can we approve (iii)? (Agreed)

Mrs Martha Pawluczyk: Setting up a completely separate system for administering this aptitude test would be costly, and we have actually no idea of the number of applicants that are likely to require this. The Board of Examiners understood this in October and were very willing for a subgroup of them to design the test, based on the information from the assessors, to administer it and then determine whether the individual has passed or not. The proposal is to actually utilise the experience within the Board of Examiners in structuring the exam and determining what questions might be suitable, with the gaps identified possibly, is the recommendation before you.

The President: Is that agreed? (Agreed)

Mrs Martha Pawluczyk: We have not processed a single temporary service provider on to the Register. The legislation has been in place since Monday 3 December. We have had one enquiry which I think was a misunderstanding as to the nature of how this applicant should be making an application for comparative assessment to join Part 1 of the Register, and that is how this individual is proceeding. We have met with colleagues at the NMC, the GDC and the GMC and have agreed that we would, as regulators, have a very uniform approach to this new provision, to the extent that we are not openly advertising it on the web. We will direct people to frequently asked questions. It is in draft format and is before a legal adviser at the moment. We have gone for external legal advice on certain issues on temporary service provision, and what you have at Appendix 2 will be scrutinised.

The frequently asked questions is based on questions that the NMC have developed and the advice is that temporary and occasional is literally what it means. It is never going to be regular part-time employment. And this is the information that we will be putting to enquirers who may wish to avail themselves of these provisions to ask whether they generally feel that the service they are intending to provide cannot be regarded as an established service, which would be under Part 1. That is the strategy I would recommend to the Council, then also to actually review what the administrative and financial burden is going forward.

Mr Graham Phillips: I think, Martha, we should be grateful to you for guiding us through this incredibly difficult process. In our anxiety around this we cannot be alone. We must have common cause with other regulators. To what extent are we working with other regulators to make common cause and deal with issues like these?

Mrs Martha Pawluczyk: Having met with the colleagues, we are sharing the information that we have on these applicants, and our approach is in line with the GMC's approach, the NMC's and the GDCs approach.

Mr Graham Phillips: In terms of developing a strategy. It seems like a lot of wheel invention otherwise.

Mrs Martha Pawluczyk: Yes. The frequently asked questions are very much formatted on the NMC. Obviously they have a wider base of scenarios which they may regard as temporary or occasional. For instance, they may have a midwife moving with her patient to another Member State with a view of delivering the child. We felt that the two indicative scenarios were all that I could come up with. If there are other suggestions of what you might wish to see, I will gladly take that on board. The advice we have had from our legal adviser is that we should not put in a timeframe of any sort, because that is like a hostage to fortune. Somebody may come and do six weeks one year, six weeks another and actually work full-time possibly for three months. So we will say that we will assess each case on a case by case basis.

Mr John Jolley: When we talk about consulting with other regulators, I do not know if we have at any time consulted with any other pharmaceutical regulators in other European countries, because the whole European system of regulations is fraught with inconsistencies from various different member countries. I would suggest to you that there are probably other pharmaceutical regulators in other European countries who are approaching this in a very different fashion to the very fair minded way that we have been discussing this morning.

Mrs Martha Pawluczyk: The only European forum in which this topic has been use raised is the Pharmaceutical Group in the EU, but there is not actually a forum of pharmacy regulators in Europe. What we are going to be doing is writing in the New Year to all the regulatory bodies that we deal with, with the memorandum of understanding, and asking them to become signatories. We will utilise the information we provide to the Department of Health and the EU Commission on the number of registrants that we have registered from those member states and say that "We do our bit, can you please provide us information and sign up to this memorandum?" I think the Health Professions Crossing Border initiative is a forum where regulators do get together, where we do actually share equal concerns on these issues. From the French order, they are equally as concerned on temporary service provision as we have been here.

The President: Although there is no world-wide organisation, there is going to be the first world regulators Conference later on in Switzerland in May. I received some information which I am happy to share with everybody. I suppose they can go with the minutes. Can we agree (v)? Agreed. Excellent work, Martha. Thank you for taking us through this complex piece of work. Well done.

[Council agreed (i) that the same paper-based assessment procedure approved by Council in August 2006 for European Economic Area (EEA) nationals with non-compliant qualifications/work experience applying to join Part 1 of the Society's Register be used for EEA nationals with non-compliant qualifications applying to join Part 3 of the Register as 'visiting EEA pharmacists'; (ii) that, where the comparison of their qualification with the national requirements for registration revealed 'substantially different matters' the Society should: require such applicants to pass an 'aptitude test' based on the Society's Registration Examination; in the first instance, adopt an oral

structured examination, possibly preceded by some practice-based scenario questions, for the aptitude test and review the appropriateness of that during 2008 in the light of experience; base the 'aptitude test' as far as is practicable, on the administrative procedures for the Society's Registration Examination, utilising as far as possible the expertise of the Board of Examiners; and develop a strategy to manage the administrative and financial burden imposed by the Directive, in the short term by adopting the current fees set for the Adjudicating Committee (comparative assessment fee plus an interview fee where applicable) when processing non-compliant applicants.

17. Any other business

Colleagues, we are in any other business.

High Court referral

Referred to the High Court under section 29(4) of NHS Reform and Health Care Professionals Act 2002 was a case involving Mrs Viviane Andraous. I ask you to note that CHRE has notified us of their decision to refer the case of Mrs Andraous to the High Court under section 29(4) of the NHS and Health Care Reforms Act 2002. This section provides that the CHRE may refer a case to the High Court if they decide that a decision is unduly lenient and/or should not have been made and they consider that the referral is desirable for the protection of the public. This is the first referral of a Society case by CHRE and Council members have been sent background information concerning the case. There has been some press coverage. I wanted Council to know that there is work on-going and we will update you as we go along.

Are there any other items?

[Council noted the report.]

President's comments

I want to say a few things. I think, if there are no other items, this is the last meeting of the year and we are in public business. As President, this has been a tough year. As Council, it has been a tough year. It began in January with dialogue with the Department of Health and subsequently followed in February by the release of the White Paper, which announced the Government's intention to split the Society into two separate organisations. We took part in the Carter Inquiry. An enormous amount of work was done by a small team and Council too contributed to that. That was followed by the formation of PRLOG and there is a tremendous amount of work that is being done on behalf of members and registrants. The other thing which occupied an enormous amount of time was the fees decision. It started with the decision early in the New Year, revisited over and over again by RMC as information became available, and eventually Council decided on the fee that we approved. It was not an easy decision, but I think with hindsight people will see it as a brave decision to ensure that pharmacists in all sectors of pharmacy benefited from a future professional body.

Also a tremendous amount of work has been done in areas like EU directives, and we have seen two examples of work that has been done on behalf of the Society. I think all the work we have done, and I am not able to mention everything, as I have not prepared for, these are things which come to mind straight away: Work done in education, science, practice, regulation and publications all are very, very, very important activities and Council has got the oversight role in ensuring it is efficient and effective to make all this happen. I have to say that without the professionalism and support of the staff members, this year would have been even more difficult. We felt that it was difficult, but I think staff have admirably worked hard and provided me, as President with support. At no time did I feel that we were lacking in expertise. One way or the other, the jobs were done on time, particularly the Carter period, which I think was very, very intense and difficult, because there were internal issues to be resolved and externally we were put under very, very heavy pressure which was avoidable and unnecessary. I want to say in public thank you to all the staff who have contributed during the year to help us do our duty with diligence and care. (Applause).

Also, this is a GB-wide body and the three National Boards in their first year were involved in quite a lot of new work. There were the new teams on all Boards. They have done a fabulous job and deserve a mention. Thanks to all three Boards and to Council members who have contributed in various ways, (working groups, committees and on Council). Some have done outstanding work and I think it is often forgotten, because of the rush of things, but this is an occasion when we should celebrate the excellent work done by all today.

Professor Bob Michell: Since we are in public session, I would like to repeat briefly something I pointed out yesterday, which is that the enormous distractions provided by the future of the Society, in other words the split, and Government policy in that area have actually detracted from the Society's ability to work in the public interest. And I will give merely one example, which is that thanks to Eileen and her colleagues we had a first class report on Scoping the Profession, we had clear ideas on how to follow that up. That follow-up is urgent, because that is follow-up work that is needed for the profession. It is not needed just for their benefit, but for the benefit of the public, who benefit from their services. Why is it in the deep freeze? Because all our resources have necessarily been preferentially dedicated to survival politics. That is not in the public interest. It is a consequence of botched politics.

The President: Thank you, Bob, with that, we close the meeting and return to confidential agendas. Items 18, 19 and 20 are for information and noting.

18. Statutory Committees: statistics

[Council noted the case statistics which had been circulated at paper 07.12/C/129.]

19. Council update and progress on strategic objectives

[Council noted the update and progress report which had been circulated at 07.12/C/130.]

20. Council for Healthcare Regulatory Excellence (CHRE): 10 October 2007 (unapproved)

[Council noted the unapproved minutes of the meeting of CHRE held on 10 October 2007, which had been circulated at 07.12/C/131.]

Professor Stephen Denyer: Mr President, I think I would like to thank you and some of your colleagues who have had to be at the frontline of some of the discussions that are taking place with the Department of Health and others. Whilst you have had the support of a lot of people, it is still mighty hard work and I would like to show my appreciation and I am sure we all would. (Applause).

The President: Thank you Stephen.

The President closed the public business of the Council.