

THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

Transcript of the Public session of the Council meeting held on Wednesday 4 June 2008

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

The Transcript of the public meeting of the Council is not the formal record of the meeting. The formal record comprises the papers presented to the meeting and the minutes as subsequently approved. The policy of the RPSGB is actively debated at the meeting. The views expressed in the transcript do not necessarily represent the Society's agreed policy.

PUBLIC BUSINESS

Present

	Vice-President	Mr M Astbury (in the Chair)
	Treasurer	Mr A Gush
Mr S Acres		Ms S Agha
Mr G Alexander		Mrs C Brown
Mr David Carter		Mr S Churton
Dr B Curwain		Mrs D Drury
Dr C Duggan		Dr P Entwistle
Mr J Gentle		Mrs S Hikins
Mrs L Jacobs		Mr R Jobling
Mr J Jolley		Mr A Kershaw
Mrs S Kilby		Ms Y Liddell
Professor B Michell		Ms A Moore
Ms M Saunders		Mr D Simpson
Mr D Thomson		

In attendance

Mr P Bennett, Chairman, English Pharmacy Board, Mr P Jones, Chairman, Welsh Pharmacy Board and Dr RM Parr Chairman, Scottish Pharmacy Board.

Chief Executive & Registrar, Mr J Holmes

Apologies for absence

Mrs M Allan, Professor N Barber, Ms J Ramsey, Professor K Wilson

The Vice-President: This morning we are starting in public business.

5. Election of the Society's Officers for 2008/2009

The first item is item 5, election of the Society's officers. The first part of the item will be introduced and chaired by the Chief Executive and Registrar.

Mr Jeremy Holmes, Chief Executive & Registrar: We have some apologies from Margaret Allan, Nicholas Barber and Keith Wilson. Jane Ramsey is not here yet.

Mr Andrew Gush, The Treasurer: I think Jane is coming. Jane is pregnant and is making a big effort to come here this morning. Bearing that in mind, do we want to wait another five minutes?

Mrs Lorna Jacobs: Are there any agenda items we can take?

Chief Executive & Registrar: I have had a suggestion, after the discussion we had yesterday about as much as possible going into public business, that we move a couple of items from the confidential agenda into the public agenda so we can cover them now. They would be item 31, which is the fitness to practise report and, subject to checking with Jackie Giltrow, item 32 the draft response to the DH Consultation, the Department of Health Framework for the Registration of Health and Adult Social Care Providers.

If we want to use the time, we might want to move item 33, which is the Revalidation Advisory Group, subject to Peter Wilson being comfortable with that. I see he is nodding. I think in keeping with the principle of as much as possible being on the public agenda, would Council be happy for us to take those items now?

(Agreed)

Mr Martin Astbury, The Vice-President (in the Chair): Thank you, Council. I was not expecting to be chairing again. **(Laughter)** I am sure it will be as much of a pleasure today as it was yesterday.

31. Fitness to Practise Report

Ms Seema Agha: This is the second report from the Law and Ethics Committee, the fitness to practise report. By way of background, in the April meeting the Law and Ethics Committee considered the draft fitness to practise report, which would be in your papers. The Fitness to Practise Report is a legal requirement of the Pharmacists and Pharmacy Technicians Order 2007. This is the first opportunity that this has been presented. I will ask you to bear with us, as I am sure there will be learning points as staff put time and effort into putting the report together.

Council's actions today are to agree the report, with recommendations of Law and Ethics Committee. I can say that the report has been given due consideration by the Committee and time has been spent going through the issues. In your Council papers you will also have received a series of pie charts which, although in back white in your papers, have been produced in colour in the publication. If anyone has any queries, we have produced these colours on a PowerPoint presentation, which is available and will be available. In addition to agreeing publication of the report, Council must make observations on the report. This is another requirement of the P&PTO Order. The lead staff member is Ros Hayles, Head of Investigations and Hearings. At the request of Council, Ros has prepared a draft observation as a starting point for Council to discuss, amend and add to. It is a good list that you will go through, Ros.

Ms Ros Hayles, Head of Investigations & Hearings: I believe Averil has copies to hand out to Council members, if you would like to see it. I suppose the obvious point is does anyone have specific questions about the content or the format of the report? I am happy to talk you through it, if you would like me to. I am not sure how much time people have had to read it themselves.

Mr Alan Kershaw: I have a couple of questions. First, this is intended to be an annual report.

Ms Ros Hayles: That is a requirement of the Order.

Mr Alan Kershaw: Is it open to amendment now, or are you just telling us what is to be ----

Ms Ros Hayles: No, it is open for amendment.

Mr Alan Kershaw: There will be time to do some re-editing?

Ms Ros Hayles: Yes.

Mr Alan Kershaw: I will have some specific points.

Ms Ros Hayles: Would you like me to talk you through the structure of the report? It starts with a forward, which has been written on behalf of the Chief Executive and Registrar, which explains why we are producing the report. It goes into a bit of detail about the changes in the fitness to practise procedures during 2007. It has obviously been a fairly momentous year for fitness to practise in the Society. There is an executive summary which has tried to pick out the most important points arising from the rest of the report, highlighting the key areas.

The next section is the introduction section, which goes into some detail about the Society generally. You may wonder why this has been included, but obviously part of the audience of the report is our stakeholders and the general public. Particularly as it is the first report we have produced, we thought it would be helpful to provide some useful background about the Society and the Fitness to Practise Committees themselves.

The next section is headed up Complaints. That really explains the process of the complaints going through the Society's mechanisms. After that we move on to looking at the workings of the specific Fitness to Practise Committees themselves. There is a very brief overview section, then a more detailed section headed up

Fitness to Practise Committees. It goes through the basic requirements, such as acting in the public interest. It looks at the committees' procedures and observation. It also then looks at the types of cases each Committee has considered during the year the Annual Report covers, and tries to highlight trends in certain types of cases and the types of outcomes. One of the requirements in the P&PTO is (a) that we describe procedures, and (b) that we provide some statistics around them. We have tried to achieve a balance between doing that; between providing some general background and producing some analysis of what the outcomes had been in the first year of operating the processes.

After the section dealing with each of the individual committees, there is a brief section about the Council for Healthcare Regulatory Excellence, as that is our overarching regulator, which mentions our interactions with CHRE during the year. Then there are the various pie charts. I think the intention is that in the published version, which is a glossy brochure in the way that the annual review is, these will be integrated with the text. They will not just be produced in a chunk at the end but, given our publication resources here, they have been produced like this for the moment. If you would like to see the pie charts in colour, we do have them on a PowerPoint which Averil can put up, which may be more helpful than seeing them in black and white.

In the final part of the report we have included three case studies. The reason we have included these is that we get a lot of requests from outside stakeholders for cases studies. It is something that other regulators often include in their similar annual reports. Some other healthcare regulators have to, or have, previously produced annual FTP reports. We thought it would be helpful to include them. Again, if Council have strong views that they should not be included, they can be removed.

Finally, appendix 3 is the list of stakeholders who we intend to proactively send copies of the reports to. Council is asked to approve that list of stakeholders and add to it, if you feel there is anyone who has been left out. We are intending that there will be a press release and an item in the PJ, when the report is published, and there will be links to it from the Society's website. So there should be relatively easy access to it to people on the website.

The Vice-President: If Council could take a couple of minutes to read draft observations, I will come back, if you have observations or comments on the report. **(After a pause)**

Mr Douglas Simpson: We are putting in these cases studies. Have they been checked out by a lawyer? Some people are identifiable. Even though they are not named, we can work out who they are.

Ms Ros Hayles: They have been checked out by the solicitor who acted in the case, and she has confirmed that any confidentiality issues are fine.

Mr Douglas Simpson: I did not want to precipitate any further legal action as a result of people identifying themselves.

Mrs Sylvia Hikins: I have some comments on the report. First of all, thank you for the report. I think a tremendous amount of work has been put into it and the first report and it is great. I have three questions. At the top of page 4, the very first paragraph, you list down basically the pie chart in percentage terms. I know it is only the first year, but perhaps a useful thing to put in future reports would be something showing trends, because just percentages on their own do not mean anything. It would be interesting to see how these might shift and the reasons why.

The second point is under outcomes in the third line, "letters of advice were issued..." Perhaps you could describe to us -- and I do not know whether this should go in the report -- what we do to follow up those letters of advice. Reading it the way it is, it sounds as though we send a letter out and that is it. I am sure that is not the case.

Thirdly, on page 11 under Complaints, it fully outlines the picture. Given that 51 percent of complainants are members of the public, how do we involve that complainant in feedback as to results? Certainly my experience as Chair of CHC is that most complainants want to see some justice, if you like, to their complaint. So it is important that they are involved in the feedback. There are three points there we could answer.

Ms Ros Hayles: In terms of including information about trends in future years that is certainly what we would intend to do. Letters of advice, and what we do to follow up, is slightly more complicated.

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We issue the letter of advice and, depending on what it is, that may be the end of the road. I would say that if a pharmacist has had a letter of advice, when an Inspector visits the pharmacy (which may be more frequently than usual), they would make sure the advice was being implemented. That is how the advice is to be done. There is not a separate follow up mechanism.

Mrs Sylvia Hikins: We do not have a letter saying, "What have you done to implement this?"

Ms Ros Hayles: Not as a matter of routine. In terms of what complainants are told about outcomes, they are routinely written to at various stages of the process, including at the end with the outcome. Sometimes then they request further information and we deal with those requests as they come in, but complainants are always notified what the outcome is. Would you like those points to be incorporated within the text?

Mrs Sylvia Hikins: I would be happy.

The Vice-President: Yes.

Mr Alan Kershaw: I have one general point, then a number of specific ones. I do not know whether you want to take time to go through page by page, but some are quite important.

The Vice-President: If they are technical, they can be taken outside.

Mr Alan Kershaw: There are others that talk of policy. Do you want it all now?

The Vice-President: Yes.

Mr Alan Kershaw: It is an excellent report and a lot of work has gone into it. I am assuming the contents are accurate. I have no way of knowing otherwise, but I am sure it has been well thought through. I am sure it is the right kind of context. The overall feel is that it is quite wordy. It is quite hard to avoid that, given the subject matter and the repetition of going through several different types of procedure. I wonder if it would be helpful to edit in a number of ways. First, if the figures and charts could be incorporated into the text, so that they come where they are referred to. I think that would be quite easy to do. If it is not, fine; put it on the table for next time. That applies to everything I am saying.

Case studies could possibly be split through the document in boxes somewhere. I have no difficulty with case studies. They are a very good idea, so let us do them, as far as we can. Report something that has been in a public hearing, as one of these has, then we do not have a confidentiality issue. If this is the first of a series of annual reports, then maybe this could be seen as a baseline, in future years topping that up, rather than going over the material again. If the material about, for example the procedures and how they work and what the rules are, if it is going to have to be repeated each year, perhaps they could be referred to in summary. That is quite a big editing job I have offered you there -- some of it easy, some longer. There may not be time, so take it as comments for the future.

Going to specifics, on page 3, down towards the bottom, Types of allegation considered, there is another figure which may be helpful, which is usually rather telling. If you relate these percentages to the number of people on the register, it will show the scale of the work and indicate how actually 100 percent of our activity is about education and standards and 0.01 percent about fitness to practise. That is not a bad figure to give.

The next is at the top of page 4, I am not sure what to make of this or not. The fact that 66 percent involves community pharmacists suggests not a significant disproportion in the profession as a whole. I would have thought, not having seen the figures that the large majority of complaints would be about community pharmacists, simply because that is where people meet pharmacists most of the time. That is what happens with GPs among doctors, for example. You will see that the number of complaints is roughly the same as the number of community pharmacists on the register. That is a point that might be worth bringing out. It gives an indication of the broad thrust of the procedures is about right.

Ms Ros Hayles: If could refer you to the bottom of page 3, it says: "Community pharmacists are (Reading to the words) ... pharmacists on the register."

Mr Alan Kershaw: If you brought that out with the actual figure, or something like it, that would highlight the point.

Top of the page 11, Lodging complaints. It may seem a semantic point, but in the first line, the complaint is not usually that the Registrant's fitness to practise is impaired. The complaint is an allegation of something that happened, and you have to consider the question whether fitness to practise is impaired. If that sounds a bit too abstruse, do not bother with it, but people do not normally say "My pharmacist's fitness to practise is impaired". They say, "My pharmacist did this and I did not like it. What are you going to do?"

Ms Ros Hayles: I take your point. I think what we did not want to say was that the RPSGB will investigate any complaint, because we do not do that.

Mr Alan Kershaw: It was an important point not to be making. Page 16, Types of allegation considered by the Investigating Committee. It is typical of this kind of report, and you are struggling with it too, to distinguish the numbers of allegations from the numbers of pharmacists involved. These figures have a habit of becoming headlines. So where you say 1061 allegations, I think I am right in saying you are talking about 619 pharmacists. You might just repeat that number, otherwise the penny in the slot thought is over a thousand pharmacists had to be disciplined.

A quick point on page 19, Composition and quorum of Disciplinary Committee. You have given the technical position in the first paragraph there under Composition and forum. I think what most people are interested in is what is the norm? How many are normally on a Panel?

Page 24 and declarations considered by the Health Committee. It is the same point as allegations versus number of pharmacists. I think the figure may be the same, but if you check that. Just a couple of points on the chart. First of all, I am glad they will be in colour for public consumption. It is virtually unintelligible otherwise. Secondly, on the bar charts there are a couple of oddities. I am looking at 2 and more particularly at 6. If we look at 6 to illustrate the point, you have got the bars, of which a number of categories have nothing on them at all; yet the chart by the side has numbers by them. For example, number 14 relates to 11 allegations, but there is nothing in the bar chart. It may be because I cannot read bar charts, I think that is probably it is a general point that needs to be checked. Some are very small, one or two, and it may just not show up, but 11 will show up whatever happens. My last point -- although I note Jane is still not here, so I could carry on (**Laughter**) -- in figure 8, the heading reads oddly.

Ms Ros Hayles: It is because in 2007, Statutory Committee inquiries were heard both by the Statutory Committee and also by the Disciplinary Committee, sitting under the old rules.

Mr Alan Kershaw: That is my misreading. I do not know whether it is worth an asterisk to explain that. It seems a bit odd.

Dr Phillida Entwistle: I just wanted some clarification, please, on the list of stakeholders. Do the lawyers include our own legal advisers and the defence cohort? What Committees are you proposing to circulate this to? In view of the interest of the membership, would it not be sensible to send this to the Branches for training purposes?

Ms Ros Hayles: I think that sounds perfectly sensible.

Mrs Sylvia Hikins: But the lawyers; are these defence lawyers or our own Legal Assessors or both?

Ms Ros Hayles: Our intention would be to send this to all lawyers who regularly appear before any of the Committees. That would include the defence lawyers as well.

Professor Bob Michell: I think I was on Investigating Committee for three years (maybe it was only two), but a recurrent factor when things went wrong was failure of GPs to give proper collaboration to pharmacists when they were in trouble. Sometimes it was fairly low level: It would have been helpful if the GP had responded in two hours rather than six. Sometimes it might have been decisive if the GP had had the courtesy to respond at all. In very few of these cases in the end did we feel that there was anything worth doing about it, because the perception was that the GPs failing was nothing that was going to go anywhere with the GMC. But my feeling was still that this kind of attitude was prejudicial to the safety of patients. One of the things I hoped would come out of the aftermath of Shipman, particularly because the flavour in healthcare regulation (certainly the theoretical flavour) is that you look at the team involved in something, not just the individual T-shirt worn by a particular professional. So it seems to me this interface between GPs and pharmacists, and GPs responding quickly to pharmacists' request for clarification, is extremely important.

If I missed it, I apologise. I see no reference to it here. If it has improved, that is great. If it has not improved, we are missing a golden opportunity to flag it up and get something done about it which is long overdue.

Ms Ros Hayles: I can clarify, there is no reference to it in the report. I take your point that it comes up in some cases, but it is not something we have routinely monitored as a factor, which is why it was not included in the report.

Professor Bob Michell: If it is not too late, I would press for there to be some reference to it, because even in the limited time that I was on that Committee -- and it more or less overlapped with Gerald's time, so he would be able to confirm what I am saying -- there were cases where it made a real difference and some where it would have made a decisive difference. But of course, failing to respond to a pharmacist for hours is not going to be anything that gets the GMC jumping up and down, but it might have saved a patient discomfort and, in some cases, danger or worse.

Ms Ros Hayles: I would be happy to include some general wording about that.

Mrs Sue Kilby: It is really to ask a question. Obviously Council have to make draft observations about this report. I am not sure what is going to happen to those draft observations. The reason I am asking is if they are going to be used as a summary somewhere as to what the key points are within this publication, then we have to make sure that the key points actually come out in this observational report, because there is a concern that people may only look at what Council thinks about the report, rather than actually going back to the main report. Therefore, we have to make sure that that is actually included within that observation. So we need to have perhaps top line numbers. The other thing which you have emphasised already is the fact of those case studies, because that is very helpful to note where we can go to get case studies, if we are not familiar with it. I wanted to raise that as a thought. If I were to come out with an observation, if you do it in bullet points, because you can capture it much more easily.

Ms Ros Hayles: To pick up your first point, audit requires that Council's observations on the report are to be published. So within the reports there is no further guidance from that, as to what they are to be. Their report currently has an executive summary which tries to highlight the key points. It may be that Council would rather the executive summary was transferred into its observations, if you like. Because I think that is more the sort of data that you are talking about. The type of draft observations we produced, I was trying to highlight key areas, in almost like a conclusion section. Whereas the Chief Executive has a forward at the start, I thought we could have Council's observations at the end, just finishing it off. But if you would rather adopt the executive summary, I can see no problem in doing that.

Mrs Sue Kilby: We have to think of how it is to be used and who will use it and what we are trying to do with it. That is all I am asking Council to think about at this point in time.

The Vice-President: A few more speakers, and then we will put the point to Council.

Mr Gerald Alexander: Just a question to Ros. I do not think you can answer it, but maybe at a future time, you may consider it when you are looking into the statistics. On figure 6, the proportion of the allegations considered by the Statutory Committee and Disciplinary Committee removal from the Investigating Committees, you will notice that in (i), dispensing errors where incorrect medication has been supplied, there were 31 cases looked at by the Stat Com/Disciplinary Committee, yet dispensing errors where there was a labelling error has more than doubled. I have never really thought about it, because having sat on the Infringement Committee for three years, it never really occurred to me that an error that was created through a labelling error was more serious than that through the incorrect supply of medicine. If you look at (i), (ii) and (iii) there is an escalating number that are referred to the Disciplinary Committee. Given that, it is something even the profession do not realise. It would be useful to notify members of our profession who are involved in the supply of medicines, through some form of law and ethics bulletin. It is interesting. (iii) is literally double (i).

Ms Ros Hayles: I do not think that is an indication that they are viewed as being more serious, but that there was a higher number of complaints that come in. Therefore, they represent a higher proportion of the total. I do not think it is because they are considered to be more serious. If that is not clear, that is something I should clarify on the figure.

Mrs Jackie Giltrow, Head of Regulatory Transition: (Inaudible) ... because yesterday I spoke to you about the narrow scope we would use for dispensing errors, where the wrong medicine is given to the wrong patient. That may account for some of that.

Ms Marcia Saunders: This is an excellent report. It demonstrates to members, if you like, the range and complexity and the real professionalism of the work we do in regulation. It is an area that is often not seen as particularly positive, but it is done to such a high standard, and it is well reflected in the report.

I have a question for Seema and yourself as to whether you feel that the lines of demarcation and links with organisations like PCTs and National Health Service Trusts are sufficiently clear and well developed. I think that partly because of the numbers of cases where there is no further action. Yet there may be an issue, which might be dealt with in a less formal way. I wondered whether that was something we might, in our next year, try to explore with a view to handing an even more robust legacy over to the regulator. I would like to suggest that. I think that would be a useful thing to do. There is a similar issue raised in the report on registration.

Mrs Alison Moore: I have two specific comments about the way things are phrased. I wondered if it could be rephrased. On page 45, where it refers to the second case study, it says one of the most common themes in cases was the supply of compliance aids, and that this case study highlights some of the potential pit-falls for pharmacists supplying medicinal products in this way. It almost reads as though the Society would much rather pharmacists did not provide medications in this way. I am sure that is not what it is intended to say. I wondered if that could it be rephrased, on page 17, where it says that reasons given by pharmacists as mitigation for dispensing errors frequently referred to excessive workload, numbers of staff and various other insufficient space and poor lighting. Then it goes on to say: "All pharmacists should draw attention to these issues if they come across them in practice." That implies it is not a good excuse, and that also it is the duty of superintendents and pharmacy owners to make sure that premises are safe to practise in. I cannot help but wonder if it is something that is frequently given as a reason, that even if all pharmacists should be reporting this and doing something about it, they are obviously not. So is there something we can do as a Society to help that, because if it is coming up frequently enough to be referred to in the report, the indication is, *Oh, those naughty pharmacists! They should be reporting that. Tut tut!* Perhaps there is something we can do to assist in that. I wonder when the pharmacists refer to this as a reason perhaps why an error might have occurred in how many cases does that then get followed with the superintendent of the pharmacy? Because it is the superintendent's responsibility to make sure that safe practice is in place. If the pharmacist says, "Hands up. I should have reported it up, but I did not," does the Pharmaceutical Society follow that up in any way?

Ms Ros Hayles: In terms of the follow up, it depends slightly on the case. Obviously if an Inspector has been to the pharmacy and there are issues with the premises and how things are being handled, then yes, action will be pursued against the company and the superintendent. I think the exception is where there has been no allegation of that nature, until you get to the hearing. Then suddenly the pharmacist says, "Actually, it is not my fault because everything was a mess and I could not do anything about it". We perhaps need to look at what we do in those instances.

Mrs Alison Moore: I wondered if there was a way we can phrase it to sound more supportive.

Ms Seema Agha: We will take that and come back to Council with some of these points that have come out today.

Mrs Lorna Jacobs: My point relates to the points in the Executive Summary on page 3, in relation to the time that it takes for investigations to go through. The paragraph, "Has significantly reduced the number of investigations that remain uncompleted six months after initiation". I was not clear -- and maybe it is in the report and I have not found it -- but it seems to me, from the point of view of our members, that the timeliness of investigations is absolutely crucial. I would like to know what is your key, what is your performance indicator, for them being completed within six months. Then following on from that, the key performance indicator that is referred to is to refer 80 percent for listing within three months. Do I understand that the idea is that once it is complete, it will be listed within three months?

Ms Ros Hayles: The listing depends very much on the availability of the Investigation Committee's timetable. All we can do in Fitness to Practise is do our best to get the cases ready as quickly as possible. So I do not think we can give you any guarantees how quickly a case will be listed.

Mrs Lorna Jacobs: I think as a regulator, that is a major responsibility we have to registrants to ensure, firstly, that the investigation is completed as quickly as possible; and secondly, that once it is completed, it is listed as quickly as possible. Whereas I understand the difficulties, I would like to think that we are constantly putting pressure on that performance indicator to make it 90 percent to be referred within three months, and possibly we can make it 90 percent listed within two months, because all of these things have a major impact on the people who are under investigation.

Ms Ros Hayles: I fully appreciate that. In terms of what we can put in the report, we are limited to only putting what is accurate at the moment. But certainly in terms going forward, our objective is always to keep improving.

Mrs Lorna Jacobs: Do we have a figure for what percentages are completed within six months?

Ms Ros Hayles: In terms of having been heard at Investigating Committee?

Mrs Lorna Jacobs: You have had the complaint. Now the investigation is complete.

Ms Ros Hayles: All we have is the information which is in there. There is another section, on page 10 with deals with KPI and we say, "A key target was to significantly reduce the number of older investigations". By the end of February this year that had been largely achieved, but we do not give the specific figure. If you would like us to, we can.

Mrs Lorna Jacobs: It would be good to be able to monitor that and to demonstrate year on year an improvement in that.

Mr Ray Jobling: It is an excellent report and I congratulate you on it. In relation to public communication of this and presentation, the essence of regulation and public protection, it seems to me, is overwhelmingly a matter of education and standards -- not just the setting of standards but making sure they are promulgated and widespread -- and that happens not just in terms of individual practice, but at a corporate level and so on. In terms of presenting this, this is really important work, as detail that is crucial. But it is the broader point in getting the public to understand modern regulation, if it is to be set within an envelope which is labelled in a broader sense, about the educational work about which this clearly is a part, in the sense of comprehensive whole.

The Vice-President: If we look at recommendation (i), from the comments I have heard would I be right in saying that Council would want our draft response to go in the style of an executive summary? **(Agreed)** I need confirmation of who will do the sign-off on this. Presumably these comments will be taken in and that would then be filtered off. Would the appropriate person signing it off be Seema or the President?

Chief Executive & Registrar: If the Council are happy, I can do it in collaboration with Seema.

The Vice-President: If we have agreed (i), with those caveats, then we agree (ii) which is to agree the Fitness to Practise Report. **(Agreed)**

Ms Seema Agha: Council, I would like to thank you and all the staff that were involved in contributing to the work in the report. We will continue the learning curve.

[Council agreed i. that the statement of observations should form part of the Executive Summary of the report when published, and ii. that the Fitness to Practise report, subject to the amendments and clarifications noted, for publication, and iii. that the final version would be signed off by Ms Agha, Acting Chairman of Law & Ethics Committee and the Chief Executive & Registrar.]

32. Care Quality Commission

The Vice-President: We now move to item 32, which Jackie Giltrow will introduce.

Mrs Jackie Giltrow, Head of Regulatory Transition: I would like to introduce this paper and take comments or try to answer any questions that you may have. By way of introduction, the Department of Health proposed establishing the new Care Quality Commission to regulate health and adult social care services in England. The powers to establish the Care Quality Commission are contained in the Health and Social Care Bill that is currently making its way through Parliament.

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What the Department of Health is consulted on is what can be included in the Care Quality Commission's new registration requirement, the scope of regulation and the regulated activities. The consultation before you will inform the development of regulation (so the statutes), and they themselves will be subject to a separate consultation, so there will be another opportunity to comment on regulation.

We have produced a draft response using the consultation questionnaire. The main area of interest to the Council is the potential for duplication of regulatory activity with the Society, and in the future the GPhC. The Department of Health has indicated that it does not anticipate that pharmacies registered with the Society or the GPhC will also be required to routinely register with Care Quality Commission. However, in time pharmacies may expand their activities to new fields which would form the scope of registerable activities, and may therefore require community pharmacies to register with the Care Quality Commission. That is the context. If anyone has any questions, I will try to answer them if I can. It is quite a long consultation.

Mr David Thomson: Just a query. I appreciate the regulatory functions, but I question why the paper has been circulated to Council when, if it is an area of practice, perhaps it could have been considered by the English Board. It is a weighty tome and it costs a fortune to circulate. It might have been a more efficient process to deal with it within the English Board context.

The Vice-President: Has the English Board seen this, Paul?

Mr Paul Bennett, Chairman, English Pharmacy Board: No, the English Board has not seen it. We would welcome sight of it.

Mrs Jackie Giltrow: It was circulated to the English Board for comment prior to coming to Council.

Mrs Christine Gray, Head of Corporate Governance: There was not time for it to go to the whole meeting. It was sent to the Chairman and Vice-Chairman of the English Pharmacy Board and all Council members serving on the English Pharmacy Board for comment in draft.

The Vice-President: It is something we will need to look at for the future, and something for the Liaison Board to look at, as well as the Council and the Boards to look at the ways of working.

Mrs Sylvia Hikins: It is a weighty tome, and I appreciate the work the staff are putting into responding to this. My only comment is on page 8/120 under chapter 3, Scope. In the main big box, we have three lines on the inclusion of complimentary therapies. We had a brief discussion about complimentary therapists yesterday, and I think they should be regulated, particularly Botox. I do not need to go into possibilities. There is a possibility of harm. I take the point that it is non-evidence-based medicine. I would like to see that final paragraph considerably strengthened to say something like rather than asking whether consideration has been given, because if you look at this on page 88, they say they do not consider that these need to be registered. So I think we should actually make a stronger suggestion that we do consider they should be registered, and we would like them to look again at these issues. I think we need to put a little bit more welly boot into it.

The Vice-President: Are there any comments specifically on that issue?

Mrs Dorothy Drury: Continuing from what Sylvia said, I would like to see an even playing field between what might be regarded as medical and what might be cosmetic. I did notice on the dental one, there was something about the tooth whitening. The chemicals for using that are really quite drastic. I think this is where we would safeguard the public.

Ms Marcia Saunders: Thanks to Sylvia for bringing that to our attention. The last sentence in the penultimate paragraph, in that same section; I think we should be careful what we wish for, because there are many healthcare professionals who absolutely would not consider administering some of these remedies. There could be a significant problem if people are told that they must get them through trained healthcare professionals, and they are refusing to provide them. I was not sure about that sentence.

Mr Steve Acres: I wanted to wholeheartedly support Sylvia's suggestion.

Mrs Jackie Giltrow: We take that on board.

Mr John Jolley: At this point, I would like to declare an interest, being a chairman of a charitable trust responsible for a residential extra care home. I would like to bear reference to Jeremy's comments in the response, chapter 2/6. I totally agree with the sentiment that that starts off with. We could probably make more of the documents that we issued late last year, in terms of the medicines management care document that we actually issued, because that is a significant improvement from previous documents available. One of the areas, reference is made is to See Sky(?) inspections. We are certainly to welcome that, but I would like to see far more emphasis placed on the level playing field that both NHS and private care homes are judged on the same basis, because there is a vast discrepancy in the standards. Also within the procedure that See Sky(?) used for their inspections, they focused very much on the procedural aspects of a care home, but very little emphasis is put on the care and the quality of care. I think that needs to be beefed up.

My third and final point here is reference to paragraph 4.11, which states that certainly the organisation and managed care systems of work in facilities and premises which do not permit that is very, very valid, but I would like included in there the fact that private healthcare (and particularly the charitable areas which are providing affordable residential care in these areas) is largely financed by social services. Because of inadequate provision by social services, many of the facilities are as they are at the moment, so rather than, say, close all the affordable private healthcare forcing people into the commercial operations, I would much rather see Government make some concerted effort to try and support financially those private healthcare facilities, and make good where there are deficiencies in the premises, because that is a real problem.

The Vice-President: Do we have agreement on this, Council?

Professor Bob Michell: I read this document with dismay and relief. Relief because, on the whole, at the moment very little is relevant to pharmacy; dismay because after all the politically correct bump about regulation with a light touch, and so on -- and if it is a bank that is about to put several million people out of business worldwide, there is no need to regulate it, because that would interfere with its success -- here, quite against the idea in real regulation that you regulate the operative unit. So you do not separately regulate the pilot, the flight engineer, the stewardess, the ground control system etcetera. You regulate what actually impacts on the user, the consumer.

If you look at page 89, it is a prescription from hell: "Examples of care that we propose would be needed to be registered: diagnosis and prescribing by a nurse or any other healthcare professional; administration of medicines under the direction of a nurse."

Who are these people? Are they creations of Kafka or what are they? **(Laughter)** The point is this, and it is an important point. The boundaries of any competent profession evolve. If someone is practising their skills with the intention of benefiting a patient, and if they are practising skills which are recognisable as a member of that profession, they should and must be regulated by the regulator for that profession, and not by some half-baked Whitehall mish-mash which this appears to be.

If someone is operating as a pharmacist, however novel the area in which they are operating, if someone is operating as a nurse with all sorts of new competencies and freedoms, they should be regulated only and exclusively. It is not just a matter of principle; it is a matter that otherwise creates infinite confusion in the minds of the public, as to who holds their interest when things go wrong, and of course the great Whitehall principle in anything is the more separate sources of surveillance you have, as in many inquiries, the better you can ensure that the real mischief falls between the cracks.

So I think some of the suggestions in here are outrageous. But what matters for the Society is a matter of principle that needs to be fought now, and not when it is too late. If a professional healthcare person is operating within the horizons of competence of that profession, they should be regulated by the regulator of that profession and not by anybody else.

The Vice-President: Do we have general agreement on that?

Ms Seema Agha: I have a question for Jackie. Is this going to move into the new regulatory framework of the entity and firm base where the entity itself is regulated, which is where the Government is going towards different types of regulation; that there are different people working within one environment, but there will be an over-arching regulator for the entity the firm base?

Mrs Jackie Giltrow: Kind of, although this is the regulated activity which is regulated.

In theory, the Government's aim is to try and get consistency. So whoever delivers the activity -- it does not matter which health care professional -- the standards for delivery of that activity are consistent, regardless of the entity within which they are delivering that service. If you like, that is the overall philosophy for the CQC, which probably explains why they are not looking at individual regulation of individual practitioners, because obviously there may not be consistency of regulation amongst individual practitioners. So if you have a nurse, a pharmacist and a doctor doing the same activity, if it is regulated activity, CQC are trying to look for consistency of approach. That is the philosophy. I am not saying whether it is correct or not.

Professor Bob Michell: I am sorry to come back, but that is typical of the Whitehall mind. What it ignores is that what matters to patients in the end is that the quality of care they receive is not only the technical competence of the healthcare professional and their ability to conform to legal requirements, this is the overarching bit that matters so much. It is the ethical code on which they were weaned. You cannot have ethical codes set up by local authorities, or any other market-based establishments. The ethical code is the life blood of any profession.

The Vice-President: If I can confirm again, we have general agreement on that point? **(Agreed)** If I can take you to the recommendations. Can we agree the recommendations there, with obviously all the caveats? **(Agreed)**

[Council agreed the draft response, subject to the amendments and clarifications noted.]

It is not often you get the pleasure of my next announcement. I have great pleasure in announcing that Jane gave birth last night. I do not have any other details. I am assuming that all is well, so I am sure we would all like to congratulate them and wish them both well. **(Applause)**

5. Election of the Society's Officers for 2008/2009

The Chief Executive & Registrar: Can we move to the election of the Society's officers for 2008/009. You will have received the names of candidates who are standing for the office of President. They are Gerald Alexander, nominated by Douglas Simpson and seconded by Sue Kilby; Steve Churton, nominated by Andrew Gush and seconded by Margaret Allen; and Brian Curwain, nominated by Steven Acres, and seconded by Sylvia Hikins. Would the three candidates declare any interests they consider relevant?

Mr Gerald Alexander: First, I am a member of the Board of the National Pharmacy Association. I am a director of the Pharmacy Mutual Insurance Company, which is in a run off situation, having redistributed some of the assets to members of the mutual fund. I also sit on the Pharmaceutical General Providence Society, which is a health protection organisation for pharmacists. I also chair the Barnet Enfield and Haringey LPC. I might have some other things I have forgotten, but they can be annexed into the record.

Mr Steve Churton: My interest is that my employer is Boots the Chemist. I have no other interests.

Dr Brian Curwain: I have nothing to declare as I am self-employed, but have no on-going contracts with any organisations.

The Chief Executive & Registrar: I would ask Council members to write the name of your preferred candidate on the ballot paper and place it in the ballot box which will be brought round as soon as you have the ballot papers. Can I ask Council to note paper 43, which is the procedure. It does not require any decision, but just to note that is the procedure we will be following. **(Vote taken)** Council, the result of the first ballot is that no one candidate has a clear majority. Therefore the two candidates with the highest number will go through to the second vote. They are Gerald Alexander and Steve Churton.

Dr Brian Curwain: May I make a brief observation to say to my co-contenders thank you for a clean contest, carried out entirely in the right spirit. I am very happy with that. Thanks to those who have voted for me. **(Applause) (Vote taken)**

The Chief Executive & Registrar: The result of the election is Gerald Alexander 12 and Steven Churton 13 votes. **(Applause)** Can I ask the newly elected President to come to the seat? I declare Steven Churton President for the year 2008, 2009. Mr Patel, would you like to come to the front of the Chamber and hand over the chain of office?

Mr Hemant Patel, Past President: Congratulations, Steven. Good morning, President. My sincere congratulations to you and commiserations to the two candidates. I wish you luck and I see a great opportunity for the Council and the Society to re-engage with the members in a meaningful way, and I hope that all the work leading up to the formation of the new professional body is successful under your stewardship. Good luck. **(Applause)**

Mr Steve Churton, the President: Before you go, may I hand you this. I understand it is a President's medal. Thank you, Hemant, for your kind words and all you have done for the Society.

Mr Hemant Patel: Thank you very much. **(Applause)**

The President: Somebody will have to tell me what to do now. **(Laughter)** With Council's permission, I would say like to say a few words after other officers have been elected. I propose we have a short break of about 15 minutes, if that is okay.

(After a short break)

The President: May I welcome the observers from the Branches and also Bill Scott, who is in the chamber as well. Welcome Bill. We will now move on to the election of the other officers of the Society. We will start with Vice President. Could I call for nominations, please?

Mr David Carter: I would like to propose Martin Astbury for Vice-President.

Mrs Dorothy Drury: I will second it.

Mr Gerald Alexander: I would like to propose Mrs Sue Kilby for Vice-President.

Ms Seema Agha: I second it.

Mr Steven Acres: I would like to propose Brian Curwain as Vice-President.

Ms Marcia Saunders: I second it. **(Vote taken)**

The President: I would like to announce the results for the Vice-President. In alphabetical order, Martin Astbury 13 votes, Brian Curwain 8 votes and Sue Kilby 4 votes. I hereby confirm the Vice-President is Martin. **(Applause)**

If we can move to the office of Treasurer. Can I have your nominations for the office of Treasurer.

Ms Marcia Saunders: I nominate Andrew Gush.

Mrs Cathryn Brown: I second that.

The President: Congratulations Andrew. **(Applause)** I have to ask Council to affirm that. **(Agreed)** So I now ask for nominations for the lay member of Council to be elected to work with the officers. Do I have nominations?

Mrs Lorna Jacobs: Alan Kershaw.

Mrs Sylvia Hikins: I second that.

The President: Can we affirm that, Council? **(Agreed)** Well done, Alan. **(Applause)** As you know, there is no Past President on the Council. The office of Immediate Past President remains unfilled. Council has agreed that for any period where there is no immediate Past President serving on Council, an additional member of Council may be elected to work with the officers. The Council member may be a pharmacy member, a pharmacy technician member or a lay member. Could I ask for nominations for the additional member of Council elected to work with the officers?

Mr David Carter: I would like to nominate David Thomson.

Mr Andrew Gush: I second that.

Mr John Jolley: I nominate Gerald Alexander, as the longest serving member on the Council.

Mr Steve Acres: I nominate Catherine Duggan.

Mr Gerald Alexander: I do not wish to accept that nomination, thank you.

The President: So we have two nominations. **(Vote taken)** May I declare the results for the fourth officers group position: Catherine Duggan 10 votes and David Thomson 15. I hereby declare that David Thomson is the fourth officer elected. That concludes the election of the officers and those Council members to work with the officers.

7. Election of a pharmacist member of Council to serve on the English Pharmacy Board

However, while we are in election mode, I suggest we continue to take item 7. The background is set out in paper 44. May I have nominations, please?

Mr Gerald Alexander: I propose Catherine Duggan.

Mr Martin Astbury, the Vice-President:: May I propose we use the same election process as we use for electing officers. In here, it is first past the post. It will make a difference if three people are standing. So I propose we use the same method as we used for electing officers.

Mr Gerald Alexander: Can I repeat that I propose Catherine Duggan.

Mr Steve Acres: I second her.

The President: Is anybody else nominated for the position? Congratulations Catherine. **(Applause)** I take it the Council does affirm that position. At this stage, could I ask whether Martin or Andrew would like to say a few words?

Mr Martin Astbury: A month ago I was delighted by the manner in which members re-elected me to Council. Today I have been overwhelmed by being elected by Council colleagues to serve as Vice-President. In three weeks' time I will be 40. Whoever said good things come in threes does not always get it right! **(Laughter)** One of the benefits of being Vice-President means that I have been able to work very closely with the Boards. I really look forward to doing that again next year. I have been deeply honoured to have worked as Vice-President this year, and in the last two weeks, when there has been no President, I have had the opportunity to chair the Branch Representatives' Meeting and Council. Most people have dreams of scoring the winning goal at the FA Cup. For me, the opportunity given to me by the support that I have from my family and work have allowed me to fulfil some of my dreams. I commit myself to do the best I can for this profession in these exciting times ahead. Thank you. **(Applause)**

Mr Andrew Gush, the Treasurer: Colleagues, congratulations to Steven, Martin, Alan, David and Catherine. It is a great team. I am honoured to be reappointed as Treasurer by Council and to be working on behalf of the membership to ensure the Society's finances remain in order. I, with Bernard and other members of our financial team, have determined our strategic objectives for 2008/009, which I would like to share with you and for you to measure us by in the coming year. The strategic objectives are:

- to produce a secure financial framework for the new professional body which is sustainable, able to deliver relevant quality services and is affordable to potential members
- for expenditure to be further directed to the benefits of our members
- to continue in dialogue with the Department of Health to secure additional funding, as financial support will be required for setting up the new professional leadership body
- for the British Pharmaceutical Conference to become an income generating event, rather than a cost to the Society. We are making great progress on this already
- to look at creative ways to solve the pension funds deficit problems
- to introduce new types of fee structures to support members;
- to produce and manage budgets for the President, Council and Committees.

Thank you colleagues for entrusting me with this great responsibility and challenge. **(Applause)**

The President: Thank you, Andrew. If I may now say a few words. Let me start off by saying what a journey, and say how honoured I am to be I think the 91st individual to be elected as President of our Society in its 167 year history.

As many of you will know, I am a relative newcomer to this place. It is even more gratifying therefore for you to have placed your trust in me to lead the Council and the profession, a profession of which I am exceptionally proud to be a member. I would first like to recognise the quality of the candidates in this election. Campaigning has been a very formative experience to me. I look forward to working with Andrew, Alan, David and Catherine, who I congratulate on their appointments, and indeed all the candidates who put so much energy into their campaigns, and of course everyone around this table who took time to research our positions and to take a very informed view. I thank you very much.

I cannot personally recall a time of so much change within our profession. Pharmacy is undergoing seismic change and the landscape in which we currently operate is likely to be unrecognisable in the not too distant future. There are high expectations of what pharmacy can offer, and public and government interest in our potential, our enthusiasm to engage and our value, is at an all time high. You only have to look at the contents of the recent White Paper to appreciate that. I believe there are some key constituencies that Council has a responsibility to lead, influence and support our people, the profession, our patients and ourselves.

First, our people. Our members, our registrants, are rightly looking to us for leadership. We need to be truly responsive to the needs of those we represent. We need to accept the reality that the Society is not well-regarded by some, and although we could hypothesise forever as to why this is the case, the fact of the matter remains that we need to raise our collective game to do more to overcome the criticisms and to demonstrate just what we can achieve, before it is too late. We should acknowledge that we have some great people working with us and we should take every opportunity to let them know we appreciate them. We must lead by example. We must be more empowering. We must support, encourage and provide them with the necessary resources and freedom to act in the best interests of our profession. As I said yesterday, I believe we need to nurture our people and be tough of the issues and not the other way around.

Secondly, our profession. In a time of great change and uncertainty we need to demonstrate strong, responsible and supportive leadership. We were all elected or appointed to serve and lead the profession, and never has there been a time more demanding of truly inspirational leadership. We have a pivotal role to play in bringing about what can only be described as a landmark moment in our proud history. I want us to pull together and to bring about the changes so essential right now to secure the future of the profession.

For those of us who are counting, we have just 391 working days left until the doors of the future professional body open for business. Just 391 days to manage the effective and safe transition of our current regulatory responsibilities to the General Pharmaceutical Council and to harness the collective expertise of all those who wish to be associated with the Society's successor body; just 391 days to construct the intellectual and tangible fabric of our future professional body and to enthuse and engage our people around a truly compelling offer. For our patients, we should never lose sight of the very real difference pharmacy makes to the millions of people in this country whose quality of life depends on our members for world-leading innovative scientific research, through to the development of new drugs and novel drugs delivery systems, the safe and effective supply of medicines and for the care which pharmacists provide every day in our hospitals and the community. We have a duty to protect and maintain the standards of health care delivery for which we are rightly renowned. Although right now we have to focus our resources on how this can best be supported in the future through new models of professional leadership and regulation, we must not be distracted from our current responsibility to the public in upholding the highest standards of pharmaceutical practice and patient care.

Last but not least, we have responsibility to ourselves. I believe we need to take stock. We started doing so yesterday and recognised the need for us to work together in a more unified, constructive and productive partnership with each other. We need also to engender the trust and confidence of others in our intention and our ability to do so.

It is sometimes easy to be overwhelmed, maybe even disheartened on occasions, with such turbulence, but we need to remain focused and have more belief in our ability to manage it. We should celebrate our successes more and we should have confidence that we can achieve great results, but only when we are aligned and motivated to. For me, a good leader is someone that inspires others to have confidence in them. A great leader is someone who inspires others to have confidence in themselves. I will work hard to re-energise and instil more confidence in all of us, so that we can absolutely achieve what we need to.

We need to stay focused on what really matters, not be distracted by what does not. We need to operate at a strategic level and not get obsessed with the detail. It is vital that we should prioritise the important issues that are really going to make a difference and not shy away from making tough decisions when we need to. In terms of our values and behaviours, we need to actively live them, not just talk about them. I think we need to be honest with ourselves and accept that there have been occasions of late when we could have demonstrated more respect for each other. Great leadership is one which appreciates diversity of experience and cultivates a range of views. In my experience the most productive dialogues are predicated on active listening, not active speaking. We need to learn to be more accepting of others' points of view and be constructive in our comments when we disagree with something or someone. We also need greater clarity in our thinking. We know that we sometimes attempted to overcomplicate things and go off at a tangent. Let us accept the need to improve the efficiency of our decision making and be less wasteful of our time and resources. Let us be straightforward and transparent, not complicated or secretive. Let us use our time more constructively during our meetings and in between to enable us to operate at a more appropriate, more effective level of leadership.

I believe passionately that we have both an obligation and an opportunity to make a step change in the way we support those we represent, and in turn to make a lasting impact on the health of those who are dependent upon them for the quality of their lives. We have a duty to all those who work in the profession to secure a future for them; a future which is professionally fulfilling; a future which encourages and supports self-development and everything we wish our profession to stand for.

It is absolutely right that we cherish our profession's heritage and it is absolutely right that we champion our profession's future. We need to provide a firm foundation on which generations of pharmacists and those who support them will build their lives. As I said in my election statement, together as a Council with world-class aspirations, a self-belief in our ability to succeed, the effectiveness of a high performing team and the determination and leadership to deliver, we have the potential and the opportunity right now to make a transformational difference, to create something we can all be justly proud of. I thank you again for your vote of confidence in me, and I commit myself today to working tirelessly with you, my respected colleagues, to achieve the successful and enduring future which I am sure we all want to see for the profession. Thank you very much. **(Applause)**

I have been advised that a 10 minute break would be in order before moving into public business.

(After a short break)

The President: Can I remind members we are in public business.

At this stage I ask the Past President, Hemant Patel, to come to the front please. This item is not on your formal agenda. I invite Hemant, as our Past President, to say a few words and present an award.

Mr Hemant Patel: Thank you, President and Council for giving me the opportunity to come and present an award which I had originally intended to present at the AGM, but that was not possible. I will not go into the history, but I have been working on it since April time with senior members of staff to get it here, but sometimes things do not happen as you plan.

What is the purpose of this Serving the Fellow Pharmacist Award? Having had the opportunity to serve the profession at a local, national and international level, I wanted to give something back to the profession by inspiring pharmacists to serve their fellow pharmacists. This is somewhat of an old tradition, but it seems to me to be dying out a bit, as evidenced by lack of volunteers at local and national levels.

Many Branches and LPCs have difficulty in recruiting members and officers of the committees. Also many posts at national level need a great deal of effort to recruit pharmacists in leadership roles. In fact, last year there was no ballot for the Society's Council election, and in Wales this year the election was uncontested. So

The Transcript of the public meeting of the Council is not the formal record of the meeting. The formal record comprises the papers presented to the meeting and the minutes as subsequently approved. The policy of the RPSGB is actively debated at the meeting. The views expressed in the transcript do not necessarily represent the Society's agreed policy.

I hope this award will raise awareness of the need to serve fellow pharmacists and become local and/or national leaders. Without leaders the profession cannot function and may indeed perish. There is also a need to encourage people to become leaders in institutions like the Government or primary care organisations, for example.

Serving the profession, fellow pharmacists, requires selflessness, discipline, compassion, a sense of responsibility for others, courage, hard work, perseverance and above all vision and faith. Taking all this into account, I am glad to award the first Serving the Fellow Pharmacist award which I am sponsoring to Bill Scott, Chief Pharmaceutical Officer of Scotland.

So what can I say about Bill? He has always been a strong advocate for the pharmaceutical profession and the provision of pharmaceutical care. Indeed, he was one of the first people to invite Linda Strang to come to Britain and talk about pharmaceutical care. He has worked to ensure society in general benefits from the unique education, training and skills which pharmacists possess. Bill is recognised as a true leader and is able to inspire others to follow. He has great vision and has an ability to share his vision. He has been instrumental in developing pharmacy services in both hospital and community pharmacy in Scotland and England. He led the development of clinical pharmacy services and instigated the first ever pharmacy strategy in Scotland, *The Right Medicine*, the strategy for pharmaceutical care in Scotland. He has introduced a new payment system for community pharmacists based on a capitation payment model, which is the first of its kind in not only the UK, but across the rest of the world. This is important as it is paying pharmacists for the specialist knowledge they possess that benefits the Government and the public. He has long advocated the philosophy of pharmaceutical care as he sees pharmacists as practitioners who provide care to patients in addition to the products.

Bill graduated from Herriot Watt University, Edinburgh in 1973 with a degree in pharmacy. In 1974 he completed his MSc at Strathclyde University and a year later in 1975 became registered as a pharmacist with the Society. After various jobs in hospital pharmacy, in 1990 he became Deputy Chief Pharmaceutical Officer at the Scottish Office, and in 1994 he became the Chief Pharmaceutical Officer at the Scottish office and is currently Chief Pharmacy officer to the Scottish Government. In 1999, if my recollection is right, I presented him with fellowship of the Royal Pharmaceutical Society certificate. In 2004, he was appointed Honorary Professor of the Robert Gordon University. In 2006 he was awarded Honorary Doctorate, again from the Robert Gordon University.

Bill also has a great sense of humour. In terms of humorous stories, he was once called in, out-of-hours to the hospital department he worked at in Nottingham, to help anaesthetise Mr Lion, who turned out to be a lion from Nottingham Zoo. **(Laughter)** Congratulations on your award, Bill. I hope the news of the award inspires more pharmacists to serve their fellow pharmacists in an inspiring way throughout Great Britain. Congratulations. **(Applause)**

Professor Bill Scott: Thank you very much, Hemant. It was actually to help to dialyse a lion. I am deeply touched and honoured by this award, Hemant. Thank you very much. Can I first congratulate Steve on being elected as President and Martin as Vice-President and the other officers who will be serving with you in these interesting times.

A favourite essay of mine appears in a book called *Pharmaceutical Essays*, which was written in the 1940s. It is an American text. There is an essay of the earmarks of a profession. The earmarks of a profession, you could list yourselves: intellectual character, a high level of University education, but above all the one that strikes me is independent judgement. For me, this is what being a pharmacist is about: representing yourself to patients and customers alike as an expert in the provision of 'care' using medicines – not knowledge of medicines, but their use.

Change generally in our profession is by evolution. Sometimes you can fall asleep waiting for it to happen. But there are moments when you make a quantum leap. A quantum leap, like shares, can go up or down. It can go forward or backward. If I give you an example of a backward quantum leap, it was the NHS contract which was introduced for pharmacy in 1948. To me that has held pharmacy back so much from where we should be. That has encouraged bean counters to count beans. Fortunately we are moving away from that. Or new contracts in all countries now are recognising a pharmacist as a provider of care and not some sort of machine for dispensing prescriptions.

A good example of leaping forwards in a quantum way for me was pharmacist prescribing. I do not think we as a profession have yet fully taken on board what that means. But for me it may actually suggest the next quantum leap, which is from the perception of pharmacist to therapist. How pharmacists evolve, does determine the rest of pharmacy -- I include contractors, managers and everyone else -- because if it were the other way about, that would be the tail wagging the dog, and more than that, it would not be good for patient care. Therefore, to make the next quantum leap will require a focused, visionary and credible professional body.

The Royal Pharmaceutical Society has been my professional body since I qualified some 30 odd years ago. It has both delighted and infuriated me. But I must say I think I have infuriated the professional body more. **(Laughter)** I was once known in Scotland as a piece of grit in an oyster, because you cannot have a pearl unless you have someone irritating it.

It is important that the GPhC does not end up with all the family jewels. The professional body must be equally involved in education, accreditation etcetera and be complimentary to the GPhC, and I do not mean complimentary in saying how nice they are. **(Laughter)**

Finally, let me pay tribute to Hemant, who has been President at a time of probably the greatest change we have had in our profession. He has personally shouldered difficulties we will never have to. It is a reflection of the man and his family that he has helped deliver the change that we are now undergoing. Once again, thank you, Hemant. May I wish the new Council every success and always remember – the government is here to help! **(Laughter)**

Mr Hemant Patel: Thank you, Bill. Thank you, President. I appreciate the Council's indulgence. **(Applause)**

33. RPSGB Revalidation Advisory Group: third update for Council

Mr Steve Churton, The President: Earlier we decided to bring item 33, paper 63, into public business, which is the Revalidation Advisory Group, third update of Council.

Dr Peter Wilson, Head of Post registration: Good morning. This is a regular report on the work of the Society on revalidation. You will recall when we originally established the Revalidation Advisory Group it was at your request to receive regular updates. The Advisory Group was established principally to advise Council, and also to generate suggestions for the White Paper Working Group on Non-medical Revalidation, the Department of Health working group. That Working Group had a number of targets to meet. It has met none of them.

The Chairman of the White Paper Working Group resigned the chair for personal reasons at the turn of the year. The Working Group is now chaired by Gavin Larner, who is the Department of Health Director of Professional Regulation For England. Mr Larner has chaired one group so far. He has made it clear that he is changing the direction of the work of the White Paper Working Group. Instead of producing a set of standards and processes for non-medical revalidation, he plans to produce a core set of revalidation standards which he will hand over to the professions to work with. There is no suggestion so far what those standards will look like, although they are likely to come from the National Health Service Knowledge and Skills Framework. It remains to be seen if the standards drawn from that framework are applicable to a contractor profession like ours or the opticians or dentists.

The consequence of his stated intention is that there will be an ongoing programme of work for the Society to do on developing standards for revalidation, and I guess -- because we do not have a forward plan -- going back to the Department of Health at intervals to talk about process, and also to compare with the other regulators involved in non-medical revalidation.

So the purpose of the paper is, firstly, to give you the update, and you have got that now. Secondly, to carry forward a proposal that you agreed in April, that the Revalidation Advisory Group should continue its functions, slightly modified, because we do not have the Department of Health targets at the moment. Also to propose the membership of a wider reference group, which was Mr Patel's suggestion, as President, to widen the cohort of organisations which are aware of the work which is going on on revalidation.

There are two errors in the paper, for which I apologise. I will take you to those as we go through. I have talked about the work of the White Paper Working Group.

The last time the Revalidation Advisory Group met, it was pointed out that there were three potential omissions from the membership: an independent community pharmacist, a locum community pharmacist and somebody with a background in public and patient interests. The paper contains suggestions to fill those gaps, but it is for Council to confirm whether or not they wish to make such appointments. The first error is to ask you to suggest a replacement for Mr Phillips, the Council nominee to the group. I think that is an error because it is probably something the officers should be considering at their first meeting on 12th June. Unless the officers or the President wish to contradict me here, I suggest we do not pursue that further today.

The second error is the last bullet point on 2.8, where there are a couple of question marks sitting there. The biggest question mark is how they got there in the first place. The word that is missing is *consistent*. The membership of the wider reference group has been pulled together somewhat from first principles. There are a number of Council members who have expressed interest in the work of the Revalidation Advisory Group. They are not members of the group and I am suggesting to you that they should join the wider reference group and receive the papers going to the group. The National Pharmacy Boards should also receive information through their Chairs. The sector groups, the community pharmacist group have already expressed interest in work on revalidation. We have met and consulted with a number of pharmacy organisations so far, particularly to enquire about how they perceive risk in the pharmacy profession and how they manage that within their organisations, particularly in the indemnity insurance organisations. They have expressed an interest in being included in the circulation of the wider reference group. Also I suggest we include the two regulators whose registrants are most similar to our own, the Dental Council and the Optical Council.

Those are the proposals to Council today for confirming the future of the Revalidation Advisory Group, the membership of the wider reference group. I think it is over to you, Council, for any questions.

Professor Bob Michell: I have a comment, and I do not mean to moderate my words. My comment will be on page 2, paragraph 1.3. Those of you who remember the politics of the Shipman Report -- and you have heard me say this before -- will recall that nothing roused Dame Janet naked fury so much as the GMC's misunderstanding of, and refusal to act properly on, revalidation. Or rather more accurately, to back peddle from what had originally been a rather reasonable set of initial suggestions. So the conclusion is that in all the backwash and hogwash that flows from Shipman, revalidation is not a peripheral issue; it is a core issue, and so it should be.

When we step on the lousiest aircraft, flying for the lousiest airline from the lousiest airport, none of us have any doubt that the pilot is competent to fly, and that is because there are proper procedures on revalidation, as there should be throughout healthcare.

[176 words removed for legal reasons.]

Mr David Thomson: A comment on the membership of the wider reference group, and a suggested amendment or inclusion of Community Pharmacist Scotland and Community Pharmacy Wales, as well as the PSNC. Also extend extending membership to NHS Education for Scotland, particularly since they have considerable experience in revalidation work already with other discipline.

Mr Alan Kershaw: Thank you, President. I will echo -- and not so eloquently -- the point Bob just made. You will remember that he and I are entirely one on this. The approach of the Department is the recipe for the slowest route to the lowest common denominator. There are outside this building in other regulators some very slow movers indeed, whose pace of change is glacial at best. Therefore, I commend paragraph 1.4. It did not take us long to come up with a pretty obvious definition of what revalidation is. The route to that will take some working out, because it is not just a sensitive issue and we are dealing with the question: can this person do their job today? It is a sensitive one, but it is multilayered, in that we need to look subtly at what will apply in different places across the profession. But that is the way forward, and let us go ahead and do it for ourselves and show how it can be done. I dare say the Department will be mightily relieved to have a good model to work from when the time comes.

Turning to the membership of groups, we will address the membership of the group itself in due course. But with that, and the wider reference group, my point is the same.

The Transcript of the public meeting of the Council is not the formal record of the meeting. The formal record comprises the papers presented to the meeting and the minutes as subsequently approved. The policy of the RPSGB is actively debated at the meeting. The views expressed in the transcript do not necessarily represent the Society's agreed policy.

I think I am right in saying that colleagues from the Welsh Board will fill in on the detail of this. The approach being taken towards revalidation in Wales is distinct in its own way, and I think we need some stronger representation perhaps from Community Pharmacy Wales, and consultation with the Board might be helpful. I do not think we need to wait for the next Board meeting, which I think is on 2nd July. I am sure there will be sources of information before then, if we need it, but I would certainly recommend that we do that.

Lastly I would ask the question why is it, since we are trying to keep the wider reference group fairly compact, that some organisations appear to have two representatives on, which seems to me excessive?

Dr Peter Wilson: The list merely represents the people we have already met with. Sometimes when you approach an organisation they come, like nuns, two-handed. It is merely a representation of that. I think that Jardine, Lloyd Thomson are two separate organisations. Lloyd Thomson are the agent, and they brought their insurance underwriter. Hang on; let me get the jargon right. We approached the broker, and the broker brought the underwriter. Two separate organisations, two separate people.

Mr Alan Kershaw: Thank you for that, but I do not think that applies to all the organisations on the list.

Dr Peter Wilson: The PDA turned up two-handed. I am happy to include just one of them, and they can rely on their internal communication processes. The other one with two names against it is the General Dental Council. What we have there is Carol Varlaam, Council member responsible for revalidation, who attends the White Paper Working Group. Frances Garrat is a member of staff. So we are looking at two different approaches to the same organisation. I would be happy to stick with one, if that is the wish of Council.

Mr Alan Kershaw: It seems if we are trying to keep this compact, doubtless other organisations will have to be considered. We probably should not allow ourselves the luxury of two from an organisation, unless they are distinct bodies.

Mrs Lorna Jacobs: The Council appointee Graham Phillips on item 2.6. Just to clarify, my understanding is that Council should agree the member, but what has happened in the past is that people are invited to express an interest and then the decision is delegated to the Officers Group.

Mr Martin Astbury, The Vice-President: I know Graham was not appointed directly as Chair of Education, but I would like Council to consider whoever is appointed as Chair of Education, takes up that position. It would be interesting to see what Council thought of that.

Mr Steve Acres: That was my thought exactly. I think that is sensible.

Dr Peter Wilson: Council members who have attended the Revalidation Advisory Group may or may not agree with me. We are not dealing with education. To a degree, at the moment we are not dealing with the principles of education. We are dealing with the principles of revalidation. We are dealing with the evaluation of risk and the role it plays in revalidation and the standards of practice, which I anticipate we will draw from the final draft of the Practice Framework.

When we move on from that, we shall be looking at techniques for the assessment of pharmacists' fitness to practise, if that is indeed where we finish up. I say that because there are resource implications. At that point, we will be looking to advise the group on assessment expertise, which is a set of expertise which is different from that required for Education Committee, looking at educational policy and the accreditation of schools of pharmacy. I am not trying to block the suggestion, but simply am outlining for you what I think would be the work programme of the group, and therefore where we look asking people to focus.

The President: Would it be a good idea, Peter, for you to circulate to Council Members a role profile for that position, and people could respond, if they wish to put themselves forward?

Ms Marcia Saunders: I am a member of the Group and I think Peter's assessment is right, and Lorna's as well, that we should call for interest and then officers should listen to both the advantages of having someone from education and the further work programme, or the current work programme. Could I come back to 1.3? The phrase that Bob left out was "a consolidated set of all regulators are signed up to." I would say that rather than being glacial, this is excitingly aspirational and totally unrealistic. It is much better to go ahead with the purpose that we have defined for ourselves. Indeed, it is on the basis of that purpose that the group has been working.

If we wait for all regulators to sign up for a set of principles, I think we will be waiting until the next Millennium, or maybe ten years.

The President: Are we all agreed that Peter should send a role profile round and we will respond to that?
(Agreed)

Mr John Gentle: I think I should start by commending the transcript of this Council meeting to the membership, because in the last two days we have had Doug outing himself as a reggae fan and expounding the merits of Jimmy cliff; Bob Michell on Kafka, Lorna on the off-side rule and now Peter with his two-handed nuns, which quite frankly is a euphemism I am still trying to work out, hopefully over lunch. **(Laughter)**

Dr Peter Wilson: I can offer the definition if you wish.

Mr John Gentle: I would like to comment on (ii), where we are being asked to agree that the Revalidation Advisory Group will work until 2009 or until the inauguration of a shadow Council of the GPhC. Again in section 2 it refers to this. I was wondering whether we should automatically dismiss the Revalidation Advisory Group when the shadow GPhC Council is formed, and whether there would be some merits, if there is still work for that group to do, to continue to do it and feed work into the shadow GPhC.

Dr Peter Wilson: It is the second, John. It is expressed that way simply because the Chief Executive and the Shadow Council of the GPhC will wish to make their own arrangements. That arrangement could start with confirming the existence, purpose and continuation of the Revalidation Advisory Group with its membership, or they may wish to do something completely different. It is just allowing for that choice.

Dr Catherine Duggan: I think I am providing a bit of reflection on the previous discussions we have had about engagement over recent days, which had included the proposal to have maybe rolling membership in wider reference groups. I wonder whether that, together with a role profile, might help us to capitalise on the most appropriate skills at the most appropriate time to move the work forward at the most appropriate pace. I think it follows on from John's comment about disbandment and keeping two bodies going at the same time. Probably in that way it is going to more easily feed into the development of revalidation by the GPhC subsequently. I think I am in support of the role profile, but also maybe the wider reference group having maybe a more flexible approach as to who may be incorporated. That can be informed by appropriate dialogue with us here, and just being kept updated.

Professor Bob Michell: I urge this body to maintain a vigorous interest in revalidation until a final scheme is agreed. The reason I urge that is clearly it will be a matter for the GPhC to make sure whatever is finally put in place provides reasonable assurance for the public that pharmacists remain competent. But if you go back to the people who pioneered an absolutely first-class system of revalidation, it is the airline industry. If you talk to any people who are involved in pioneering that, one of the things they will tell you is that the reason it works so well is that it is held in the highest regard by those who fly planes and those who control planes. It is devised by and overseen by people who are absolutely at the top of their profession, not retired people with time to do it, or anything like that.

The point I make is yes; on the one hand, it is important that the public and the GPhC as their proxy are persuaded that this tests what needs to be tested, to make sure people are still competent. But it is equally important that the profession itself regards it as a scheme which tests what matters, and does so in a realistic and proportionate way. My advice would be do not just leave it to the GPhC, not initially at any rate.

Mr Steve Acres: Appendix 5, the proposed membership of the wider reference group, has Lesley Morgan on it as a Council member. Lesley is no longer with us. I think it would be useful to have a technician on the wider reference group.

Mr Martin Astbury: My point was point (iii) on the required action. We have talked about the appointments process for the Council member. I was wondering if Peter could explain what the appointments procedure was for how we came to the three names being put forward .as being recommended to take up these positions.

Dr Peter Wilson: It is not an appointments process that is happening now potentially. What I have done here is to make suggestions, based on what we know about the people we have worked with. So the independent community pharmacist is somebody that has done some work with our pre-registration team.

The locum is one of the few locums I actually know who has also been a CPP tutor and has done some work on a Society Committee with us, so she knows the Society as well. The third person was a suggestion which arose from the PPI group, chaired by Lorna. She has the added benefit of some experience of revalidation in medicine.

Mrs Dorothy Drury: I wanted to make sure that when we are talking about this, we may not have this formal group doing a lot of work, but that pharmacists are definitely keeping up-to-date. I have free three accreditations with me I have been trying to do whilst I am in London. Pharmacists are aware and we are keeping up to date.

Professor Bob Michell: That is exactly the point: the potential to confuse CPD with revalidation. The two are different. Revalidation is what it says, and as Dame Janet said explicitly. That was the problem with the GMC scheme. It was going more and more towards being based on routine appraisal, on the one hand, and earning Brownie points by going to courses on the other. All that is important and necessary, but what revalidation hinges on is the demonstration of competence – re-demonstration of competence -- not the means by which that competence is maintained. That is why I said before in Council some years ago, ultimately if revalidation becomes compulsory, there is no reason for CPD to be compulsory. It is up to people how they maintain their competence.

The President: Could I propose that we go to the recommendations in the paper? The first one we have heard on is an update. (ii) is to agree the continuation of short-term RAG. Are we agreed? **(Agreed)** (iii) is to agree the amended membership, subject to the conversation we have had. (iv) we have changed, such that Peter will circulate a role profile and those interested will submit their names. (v) is to agree the amendments and the remit for the RAG. (vi) is to confirm the amended remit procedures and membership of the wider reference group. **(Agreed)**

Dr Peter Wilson: Subject to the points made.

[Council i. received an update on progress towards developing RPSGB policy for the prospective introduction of revalidation in pharmacy; ii. agreed the continuation of the short-term non-medical revalidation advisory group (RAG) until June 2009 or until inauguration of a shadow council of the General Pharmaceutical Council; iii. agreed amended membership of the RAG to include three additional appointees (an independent pharmacist member, a locum pharmacist member and a representative of the Society's PPI Liaison Group) as set out in the paper; iv. agreed that a Council member to replace Mr Graham Phillips on the RAG should be agreed by the Officers following a request for expressions of interest from Council members. A role profile would be developed and circulated with the request to Council members. v. agreed amendments to the remit for the RAG as set out in the paper; and vi. confirmed the amended remit, procedures and membership for the Wider Reference Group for revalidation (WRG), account having been taken of the amendments proposed by the Council.]

The President: Thank you Peter. That is the end of public business.

The President closed the public business of the Council